

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gertrude Inez Kane			2a. DATE OF DEATH MONTH DAY YEAR September 29, 1986		2b. HOUR 5:55 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 5, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hosp. of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Cashier	12b. KIND OF BUSINESS OR INDUSTRY P.G. Hospital	
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Cheverly	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6313 Joslyn Place 20785	
14. FATHER'S NAME FIRST MIDDLE LAST John Lape		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Elliott		ADDRESS 6313 Joslyn Place Cheverly, Maryland	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 162-16-0807		17. INFORMANT June Fineran (Daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) COLD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2m. 3-4 weeks years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Senile Dementia + Esophageal Thrombosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from August 8th, 1986, to 9-22, 1986, that (I) (we) last saw the deceased alive on 9-28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ohannes Sahakian, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5632 Annapolis Rd. Bladensburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/01/86	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE	

BP

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

00-19382

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 6 / 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Peter (nmn) Kell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Sept 23 - 86</i>		2b. HOUR MIN. <i>12:45 AM</i>					
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 25 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD.				
10. CITY OR TOWN OF DEATH <i>LAUREL</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greater Laurel Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>15607 Bounds Ave. 20707</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clarence Kell</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR CLASS) <i>-----</i>		17. INFORMANT <i>Richard Kell</i>		ADDRESS <i>same as 13e</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *Lung Cancer*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Tobacco Addiction*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*10 months**YRS.*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN 19 86</i> , to <i>SEPT 23 19 86</i> , that (I) (we) last saw the deceased alive on <i>9/12 19 86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>R. MacGin</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/23/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. MACGIN</i>		22e. ADDRESS <i>14333 LAUREL BOWIE RD 307</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/25/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cem. Co.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Drexel Hill Delaware Pa.</i>	
24. FUNERAL DIRECTOR NAME <i>FLECK FUNERAL HOME INC. LAUREL, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal (IMPORTANT: If item 21 is marked for item 18, showing injury, or other traumatic event, the medical examiner must be notified at once).

COTTON BIRD



0-18293

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELIZABETH S. KEMP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 05 86</b>		2b. HOUR MIN <b>8 10 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 13, 1910</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Hampshire</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. George's</b>		13c. CITY OR TOWN <b>Bowie</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>M. Norcross Stratton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Elizabeth Hickey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-70-4451</b>		17. INFORMANT ADDRESS <b>Rosemary S. Vincent 16004 Pond Meadow Lane Bowie, MD 20716</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b>		<b>10 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>		<b>2 yrs.</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Acute Renal Failure.</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <b>8/26/86</b> 19____, to <b>9/5/86</b> 19____, that (1) (two) lost to the deceased alive on <b>9/5/86</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (showing (we) I did (did not) view the body after death)			
22b. SIGNATURE <b>Richard A. Andruselli MD</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard A. Andruselli MD</b>		22e. ADDRESS <b>PG. Cardiology</b>	
22c. DATE SIGNED <b>9/6/86</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>SEPT 10, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton, Pr. George's, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1986</b>		25b. REGISTRAR'S SIGNATURE	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



00218584

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file it in the file of the deceased with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, please see the instructions on the back of this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 2 6 / 1 1			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Virginia M. Kendall</b>				2a DATE OF DEATH MONTH DAY YEAR <b>September 3, 1986</b>		2b HOUR <b>8:00 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>March 2, 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>73 years</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10 CITY OR TOWN OF DEATH <b>Temple Hills</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5501 Winston Street</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Private Ind.</b>	
13a STATE <b>MD</b>				13b COUNTY <b>Washington, DC</b>		13c CITY OR TOWN <b>Washington, DC</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Shields</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Bryant</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS <b>2515 13th St., N. W.</b> <b>Juit B. Kendall, Son, Washington, D. C.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease years</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>80</b> , to <b>Sep 3</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>March 4</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE <b>Merril Stock</b>				22c DATE SIGNED		22d ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22e PHYSICIAN'S NAME (TYPE OR PRINT) <b>MERRIL STOCK, M. D.</b>				22f ADDRESS <b>1145 19th Street, N. W., Washington, D. C.</b>			
23a BURIAL, CREMATION, REMOVAL (S) <b>BURIAL</b>		23b DATE <b>10 Sep 86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Maryland Nat Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Maryland</b>	
24 FUNERAL DIRECTOR <b>W. ERNEST JARVIS CO., INC., Washington, D. C.</b>				25a DATE REC'D. BY REGISTRAR <b>SEP 15 1986</b>			
				25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

102-15503

6:00 AM

December 3, 1964

Virginia W. Kennedy

12 years

12-3-1952

Black

Female

James George

XX

U. S. A.

White House

Private Inc.

Washington

1001 Madison Street

White House

1001 Madison Street, N. W.

Washington, D. C.

White House

White House

1001 Madison Street, N. W.

Washington, D. C.



10

12

13

14

15

1001 Madison Street, N. W., Washington, D. C.

1001 Madison Street, N. W.

James George

12-3-1952

Black

Female

White House, Washington, D. C.

00-18178

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

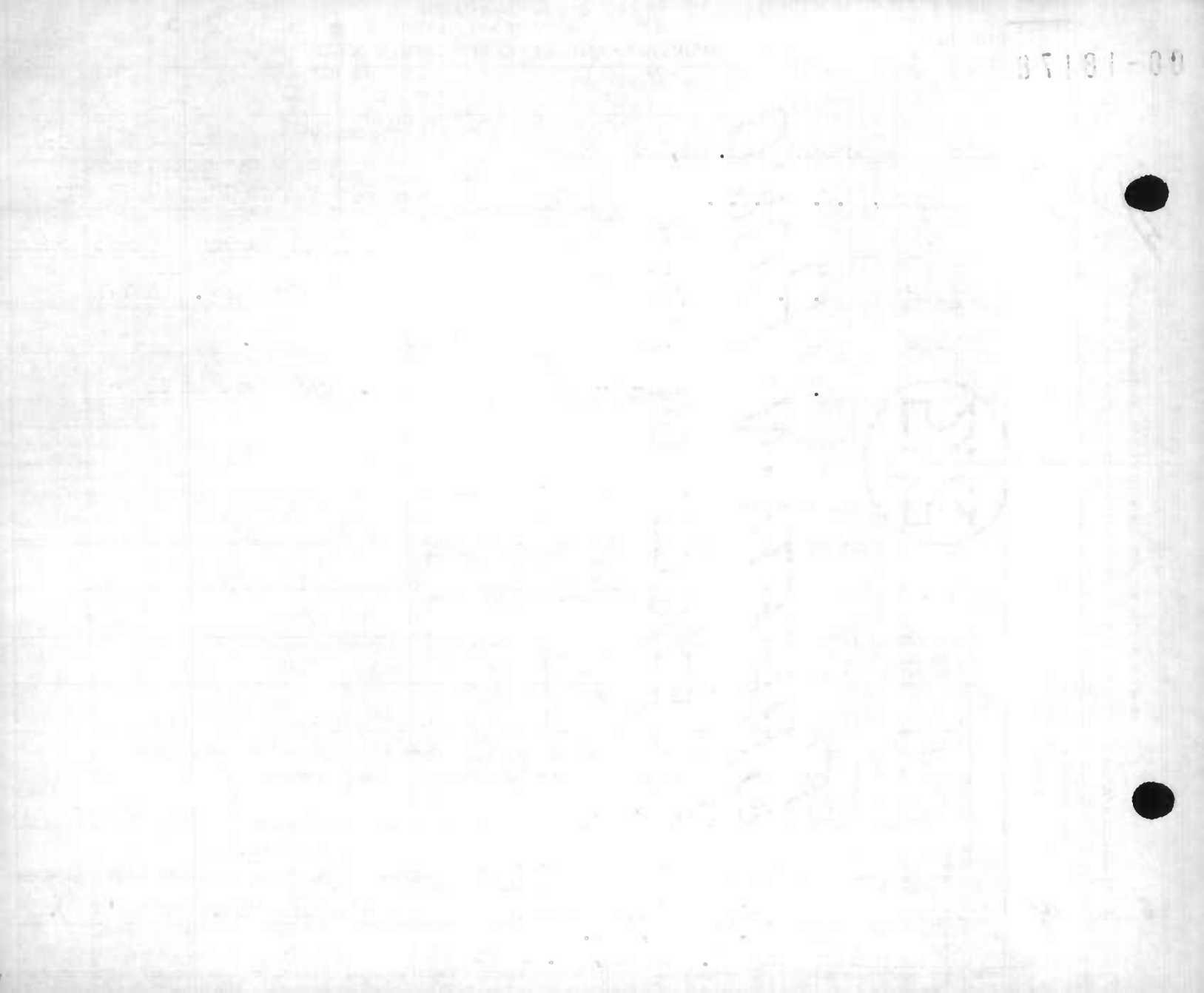
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
BERNARD DOUGLAS KEYS						9-10-86			19			M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		Caucasian		Sept. 11, 1953		32 YRS.						9-10-86		19 9:30a					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Washington, D.C.			U.S.A.						Prince George's County MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Temple Hills			3000 Brinkley Station Drive						Shingel Roofer			Construction							
13a. STATE												13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		13e. ZIP CODE	
Maryland												P. G.		Temple Hills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3905 23rd Pkwy. 20748	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
Douglass Clayton Keys						Margaret H. Taylor													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
No						N/A						217-60-8564 Douglass C. Keys Same as 13 A-E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Hanging																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				7:55 AM 9-10-86				subject hanged self											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				construction site				3000 Brinkley Station Drive Temple Hills, Md											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED							
Margarita A. Korell, M.D.				M.D. Assistant								9-10-86							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Margarita A. Korell, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Cremation				09/11/86				Lee Crematory				Clinton Prince George's MD.							
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Lee Funeral Home, Inc.								SEP 16 1986				[Signature]							
6633 Old Alexander Ferry Rd. Clinton, Md. 20735																			

07:84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))



00-17227

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MALAK K HODAYAR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09-01-86</b>			2b. HOUR <b>5:56 A M</b>				
3. SEX <b>FEMALE</b>			4. RACE <b>IRANIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 1 1910</b>				
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IRAN</b>			7b. CITIZEN OF WHAT COUNTRY? <b>IRAN</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
9. CITY OR TOWN OF DEATH <b>CLINTON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>				
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>B.G.</b>			13c. CITY OR TOWN <b>ET. WASH.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>K HODAYAR K HODAYAR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NOSRAT G HASARI</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>213 04 4824</b>			17. INFORMANT <b>PARIVASH MOSTAAN</b>			17. ADDRESS <b>SAME #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8/11</b> , 19 <b>86</b> , to <b>9/1</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8/31</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R. Mostaan</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9/1/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>REZA MOSTAAN</b>			22e. ADDRESS <b>4235 25th Ave NW 20745</b>							
23a. BURIAL, CREMATION, REMOVAL (DIRECT BY) <b>BURIAL</b>			23b. DATE <b>SEPT. 3, 86</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ISLAMIC GARDEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH, VIRGINIA</b>	
24. FUNERAL DIRECTOR'S NAME <b>DEVOL FUNERAL HOME</b>			24. ADDRESS <b>WASH. D.C.</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 08 1986</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Dendron-Kindach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within one hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



COLLECTION

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "I have" and "I am" are faintly visible.]*

*[Faint text at the bottom of the page, possibly a signature or date.]*







DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-17326

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8626715									
1. DECEASED NAME (TYPE OR PRINT) <b>Ralph T. KIRKPATRICK</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>September 5, 1986</b>		2b. HOUR MIN. <b>5:20 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 16, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
12. CITY OR TOWN OF DEATH <b>Bowie</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12430 Lanham-Severn Road</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plummer</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Union</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George's</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>12430 Lanham-Severn Road 20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Kirkpatrick</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie Tarnner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- - -</b>		17. INFORMANT ADDRESS <b>Alice E. Kirkpatrick same as 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 year</b> <b>5 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> 19 <b>75</b> , to <b>9/5</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>9/5</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>see the body after death</b> .									
22a. SIGNATURE <b>Dr. Leonard P. Appel</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>SEPT 8, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Leonard P. Appel, M. D.</b>				22e. ADDRESS <b>A-6 3231 Superior Lane Bowie, MD 20715</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>SEPT 8, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Pr. George's, MD</b>			
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				ADDRESS <b>16000 Annapolis Road Bowie, MD 20715-3043</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Alice E. Kirkpatrick</b>	



00-18229

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 1 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES H. KLIPPERT			2a. DATE OF DEATH MONTH DAY YEAR 09-11-86			2b. HOUR 4:45AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 2, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Gas Stove Co.	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9608 Autoville Drive 20740	
14 FATHER'S NAME FIRST MIDDLE LAST Walter Klippert				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-5454		17 INFORMANT ADDRESS Mrs. Patricia A. Monroe 8516 60th. Place Berwyn Hgts, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral Pneumonias</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Poor Gag Reflex</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Organic Brain Syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1986</u> to <u>Sept 11, 1986</u> , that (I) (we) last saw the deceased alive on <u>Sept 5, 1986</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did (did not) view the body after death.)									
22b. SIGNATURE <u>Stuart J. Turkewitz, MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9/12/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Turkewitz, MD				22e. ADDRESS 7500 Greenway Center Dr. Greenbelt, Md. 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/12/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria N/A Virginia			
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 20M  
(VRA 15, 4) 7/78

SEP 18 1986



00-17119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as seen, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth NMI KMET			2a. DATE OF DEATH MONTH DAY YEAR September 3, 1986		2b. HOUR 2:20 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCT. 21, 1894	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.			
10. CITY OR TOWN OF DEATH LANHAM	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOCTORS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER.		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD	13b. COUNTY PR. GEO.	13c. CITY OR TOWN LANHAM	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8912 WOODBURN COURT 20706		
14. FATHER'S NAME FIRST MIDDLE LAST ANTAL KMET		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUZANNA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 367 20 1125		17. INFORMANT ADDRESS IRENE K. EDGAR - 8912 WOODBURN CT. LANHAM		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE. DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ANEMIA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from AUG. 18, 1986, to SEP. 2, 1986, that (I) (we) last saw the deceased alive on SEP. 2, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE ZLKZ MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/3/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YEAR-KWON H. YOON		22e. ADDRESS 5506 KENDWORTH AVE. RIVERDALE MD 20737				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 6, 1986	23c. NAME OF CEMETERY OR CREMATORY Woodmere Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Detroit Michigan		
24. FUNERAL DIRECTOR NAME Takara Funnell-Horne		ADDRESS 254 Carroll St NW		25a. DATE REC'D. BY REGISTRAR SEP 5 1986		
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers				





0-17903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 6 2 6 / 1 8	
1- FOR STATE REGISTRAR		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST Curt		MIDDLE A.		LAST Krumpe	
2a. DATE OF DEATH		MONTH September		DAY 8,		YEAR 1986	
2b. HOUR 4:30a		M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH April 23 <sup>rd</sup> , 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH Mt. Rainier		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3203 Queenstown Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN P.G.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3203 Queenstown Drive 20712	
14. FATHER'S NAME FIRST Curt		MIDDLE A.		LAST Krumpe		15. MOTHER'S MAIDEN NAME FIRST Minna	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-16-6503		17. INFORMANT Thelma L. Krumpe (Wife) Same as #13		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest secondary to arrhythmia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u>							<u>Unknown</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Old stroke, Insulin-dependent diabetes mellitus.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>December</u> , 19 <u>66</u> , to <u>September 8</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>August 22</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Medical Examiner notified.</u>							
22b. SIGNATURE <u>Carl J. Houmann</u>		DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-8-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carl J. Houmann, M.D.		22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 09/09/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FRANK'S CASCH'S SONS FUNERAL HOME, PA. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

BP

60071-0

0-19248

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR			
LINDA Lee KUBOVETZ				MONTH DAY YEAR 9 20 1986				M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Dec 23 1950	35 YRS.	MONTHS DAYS		HOURS MIN		MONTH DAY YEAR 9 22 19 86		3P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC		USA				Prince George's County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Temple Hills		5833 Fisher Rd. #11				Teacher		Parochial School			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
Md Pr Geo Temple Hills YES <input type="checkbox"/> NO <input type="checkbox"/> 5833 Fisher Road #11											
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Donald M Coakley						Ethel M Walker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				3904 Brinkley Rd Temple Hills, Md.	
No				577-68-9205		Ethel M Coakley					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anorexia nervosa</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 9-23-86			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		25Sept86		Cedar Hill Cemetery				Suitland PG Md			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E Wilhelm Funeral Home						Suitland, Md.		SEP 26 1986			

0-18514



00-18295

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jean Haynes Kurtz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 14, 1986</b>		2b. HOUR <b>10<sup>30</sup> A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 13 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> <b>16 13 14</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD	
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6000 Glenn Dale Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Glenn Dale</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Claude L Haynes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Hicks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>430 12 217</b>		17. INFORMANT NAME ADDRESS <b>H. James Kurtz 6000 Glenn Dale Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction, Lateral Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>None</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1 Jan 1950</b> to <b>9-14-86</b> , that (I) (we) last saw the deceased alive on <b>9/14/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.							
22b. SIGNATURE <b>W. H. Ferguson</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/14/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. H. Ferguson MD</b>				22e. ADDRESS <b>4701 Randolph Rd, Rockville Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept 18 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				ADDRESS <b>16000 Annapolis Road Bowie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, always any injury, or other traumatic event, (as indicated on page 1).

BP

August 14, 1963

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Lester

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26721			
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH ESTIMATED						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHRISIANTHIA D. LAMBERT						MONTH DAY YEAR 9 20 19 86						M 6:07 PM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH (MONTH DAY YEAR) APR. 2, 1971		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 15		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 9 20 19 86		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR PREVIOUS 12 MONTHS) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VIRGINIA				13b. CITY OR TOWN ALEXANDRIA				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 253 TENN. AVE. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE C. LAMBERT						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS PRUITT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 225-35-5282				17. INFORMANT ADDRESS GEORGE C. LAMBERT 253 TENN. AVE. ALEXANDRIA, VA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7 9259 IMMEDIATE CAUSE (a) <u>Electrocution</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? Body Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 4:14 P.M. 9-20-1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject came in contact with high tension wire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) field				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6100 blk. N. Hillman Circle, Suitland, Prince George's MD					
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9-21-86					
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE SEPT. 25, 86		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE FT. MYER, VIRGINIA			
24. FUNERAL DIRECTOR NAME Helen Green				ADDRESS GREENE FUNERAL HOME, INC. 14 FRANKLIN STREET ALEXANDRIA, VIRGINIA 22304				25. DATE REC'D. BY REGISTRAR SEP 28 1986					
25b. REGISTRAR'S SIGNATURE John Smith													

DHHM - 17  
(VR A15 ME (5))

00-10810

PLACE DATE

RECEIVED

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RECEIVED

86 APR 1968



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00-18072

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Isabel B Lane		2a. DATE KNOWN OF DEATH 9-2-86		2b. HOUR 234	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 8-4-08	6. AGE (IN YEARS) 78 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. BIRTHPLACE (CITY OR TOWN) USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife	
13a. STATE Maryland		13b. COUNTY Queen Anne's		13c. CITY OR TOWN Centerville	
14. FATHER'S NAME Charles Wrightson		15. MOTHER'S MAIDEN NAME Mary Ford		16. WAS DECEASED EVER IN U.S. ARMED FORCES? No	
17. INFORMANT Daughter		18. SOCIAL SECURITY NO. 214-39-7982		19. ADDRESS 310 S. Liberty St. Centerville, Md. 21617	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Isotonic pelvic and uterine disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE Augusto P. Rodriguez	TITLE (SPECIFY) Deputy	DATE SIGNED 9-2-86
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez MD	ADDRESS 5009 Rayburn Ch. C.P.S., Pico Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sep. 5, 1986	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Centerville, Q.A.Co., Md.
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centerville, Md. 21617		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE SEP 08 1986 Julia Davidson-Pendall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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0-17925

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and properly filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 2 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) KING YUAN LEE		MONTH DAY YEAR SEPTEMBER 8 1986		10:38A <sub>M</sub>	
3. SEX Male	4. RACE Chinese	5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) Taiwan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA		13b. COUNTY Fairfax		13c. CITY OR TOWN Herndon	
14. FATHER'S NAME FIRST MIDDLE LAST Pen Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shin Yuan Wu		16. STREET ADDRESS / ZIP CODE 1245 Elden Street, Apt 301, 22070	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-80-1957		17. INFORMANT Mei Hwei Lee (wife) Herndon, Virginia 22070	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepa Tom a</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hepa Tom a</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>86</u> , to <u>9/10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> , 19 <u>86</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) TSUNIE CHANCHIEN, M.D.		22c. DATE SIGNED 9/8/86		22d. ADDRESS 8824 Cunningham Dr., Berwyn Hgts, Md. 20740	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation, Removal		23b. DATE 9/10/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
24. FUNERAL DIRECTOR J. Berkley Green, Green Funeral Home, Herndon VA		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		25a. DATE REC'D. BY REGISTRAR SEP 15 1986	

SEP 15 1986

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CHIEF IN CHARGE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36 26124  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Luia Lee</b>			20. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> <b>9-7-86</b>			2b. HOUR <b>35E</b>		
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> <b>4-23-06</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>80 YRS.</b>	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> <b>9-7-86</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Palmer Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7627 Muncy Road</b> <b>28785</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mac McCullough</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Thompson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>577 30 6631</b>		17. INFORMANT ADDRESS <b>Mary Handy-niece-1305 Emerson Street</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspergillus candida meningitis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		N.W. Washington D.C.	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>9-7-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 13, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park Landover, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>John T. Stewart</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodriguez</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 11281

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

8 6 2 6 / 2 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST RAQUEL		MIDDLE V.		LAST LEGER		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
								09 10 86			11 30 PM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 04 10 23		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Haiti		7b. CITIZEN OF WHAT COUNTRY? Haiti		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef		12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 162 Old Enterprise Road 20772		
14. FATHER'S NAME FIRST MIDDLE LAST Simon Leger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fanezi Damisca								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-78-5921		17. INFORMANT 162 Old Enterprise Rd. Occeana V. Leger, Upper Marlboro, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe bradycardia and complete heart block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma of lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Hypertension, Acute myocardial infarction, renal failure,</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> 19 <u>86</u> , to <u>9-10</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>9-10</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>R. Due Lag</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAVINDER K. RUSTAGI				22e. ADDRESS 6132 LANDOVER ROAD CHEVERLY, MARYLAND 20785								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/15/86		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park Landover				23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Maryland				
24. FUNERAL DIRECTOR NAME J.B. Jenkins Funeral Home, Landover, Maryland				24b. ADDRESS 7474 Landover Rd.				25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove stubs on pages 1 and 2 and mail them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-15851





00-19250

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHESTER ELWOOD LEESE</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>21</b> YEAR <b>86</b>			2b. HOUR <b>3:00 A.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>15</b> YEAR <b>98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA, USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.			
10. CITY OR TOWN OF DEATH <b>BELTSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3128 FALLSTON AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physiologist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEACHING</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>PR. GEORGES</b>		13c. CITY OR TOWN <b>BELTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3128 FALLSTON AVE. 20705</b>	
14. FATHER'S NAME FIRST <b>FRED</b> MIDDLE <b>LEESE</b> LAST <b>LEESE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Georgia</b> MIDDLE <b>Thompson</b> LAST <b>Thompson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17. INFORMANT ADDRESS <b>Marilyn L. DesRoches Daughter Same as 13</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIO PULMONARY**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **CONGESTIVE HEART FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **LONG STANDING CARDIOMYOPATHY**

2 MO.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

**AORTIC STENOSIS**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>viewed</del> attended the deceased from <b>JANUARY 19 88</b> to <b>21 SEPT. 19 86</b> , that (I) <del>lost</del> saw the deceased alive on <b>16 SEPTEMBER 19 86</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRILL C. QUINNAM JR.</b>				22c. DATE SIGNED <b>9-21-86</b>		22d. ADDRESS <b>11120 NEW HAMPSHIRE AVE. SILVER SPRING</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sep. 24, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>Pr. Geo. Maryland</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins, Jr.</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John E. ...</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

W. J. COLEMAN



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>LILLIE Mae Leigh</b>			7a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>8-27 1986</b>			7b. HOUR <b>4:30 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 14, 1938</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>48 YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>8-27 1986</b>			7d. HOUR <b>4:30 PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>P.G. Co., MD</b>		
10. CITY OR TOWN OF DEATH <b>Prince Georges</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince Georges General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse-aide</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Capron</b>		13c. CITY OR TOWN <b>Capron</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>P.O. Box 51</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT EVANS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WILLIE BARROWS</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>225 70 8363</b>		17. INFORMANT <b>HUSBAND</b> ADDRESS <b>JOSH LEIGH, JR., PO Box 51, Capron, Virginia</b>				
18. CAUSE OF DEATH (Enter only one cause, or list for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic cardiomyopathic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		M.D.		MEDICAL EXAMINER		DATE SIGNED <b>8-27-86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>8/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHILOH CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>South Hampton Co., VIRGINIA</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>ALEXANDER S. POPE-2617 Pa Ave., S.E.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 05 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Henderson-Randall</b>		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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BP  
DHWM - 17  
(VP A15 ME (3))



00-19587

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Wanda T. LICHTENBERGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 28, 1986</b>		2b. HOUR AM PM <b>10:30 AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>December 1, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Bowie</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3336 Memphis Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home-maker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3336 Memphis Lane 20715</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Zigmund Dudkowski</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Rogacki</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>	17. INFORMANT ADDRESS <b>Louis A. Lichtenberger, Jr. same as 13e.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LUNG - CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 mos 1 year</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>HYPERTENSION</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>---</b> P.M. 19 <b>86</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>SEPT 19 65</b> to <b>SEPT 19 86</b> , that (I) (we) last saw the deceased alive on <b>MAY 19 86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Leonard P. Appel</b>		22c. DATE SIGNED <b>SEPT 29, 1986</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. PHICIAN'S NAME (TYPE OR PRINT) <b>Dr. Leonard P. Appel, M. D.</b>		23b. ADDRESS <b>3231 Superior Lane A-6 Bowie, MD 20715</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>OCT 1, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton, Pr. George's, MD</b>		
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>	16000 Annapolis Road Bowie, MD 20715-3043	25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>	25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

10:30 AM September 20, 1960

September 1, 1950

Prince George's County

Home - 1000

3330 Memphis Lane 20112

Home - 1000

131-22-5720 Home - 1000

131-22-5720 Home - 1000

131-22-5720 Home - 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 DOM 7/B4  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE D LLOYD			2a. DATE OF DEATH MONTH DAY YEAR 08 21 86		2b. HOUR 12 50 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 - 5 - 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PGGHOSPITAL AND MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN Wash., D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 817 Jefferson St., N.W. 99920011	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jackson Scott	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Davis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 579-60-9555		17. INFORMANT Martha Lloyd		ADDRESS 817 Jefferson St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Uncontrolled Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5-23-</u> 19 <u>86</u> , to <u>8-21-</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>M. K. Mohan</u>		DEGREE MD		22c. DATE SIGNED 8/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. K. MOHAN		22e. ADDRESS 6510 KENILWORTH AVE, RUMBLE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE August 26, 86	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.	23e. DATE REC'D. BY REGISTRAR AUG 28 1986	
24. FUNERAL DIRECTOR NAME W. ERNEST JARVIS Co.		25a. DATE REC'D. BY REGISTRAR AUG 28 1986			
ADDRESS 1432 Yoo St., N.W.		25b. REGISTRAR'S SIGNATURE Julia L. Jordan			

0-47694

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00-19576

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANXIOUS, IF ANY, IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>Ruth Moore LoCastro</b>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9-21 1986</b>			2b. HOUR M <b>18</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6-3-27</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>59</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9-21 1986</b>	7d. HOUR M <b>18</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>District of Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD			
10. PLACE OF BIRTH <b>Bowie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2515 Kayhill Lane</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo's</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2515 Kayhill Lane/ 20715</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert L. Moore, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy -- Greer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Route 2, Box 55-B, Peter Paul Lo Castro- Homosassa, Fla. 32647</b>				
18. CAUSE OF DEATH (Enter only one cause, or (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interdissective Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>9-21-86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>			ADDRESS <b>5009 Rayburn Ct., Temple Hills, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/25/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leeland (Pr. Geo's) Md.</b>		
24. FUNERAL DIRECTOR <b>Richard A. Coleman</b> Funeral Home				- Upper Marlboro, Md. 20772		25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>		25b. REGISTRAR'S SIGNATURE	

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

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10-12-1941  
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10-12-1941  
1-9

10-12-1941  
1-9

00-19199

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 1 3 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>WILLISTON H. LOFTON</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9-14-86</b>		2b HOUR <b>7:40 A</b>
3 SEX <b>M</b>	4 RACE <b>BLACK</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>11-27-07</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10 CITY OR TOWN OF DEATH <b>Adelphi Md.</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presidential Woods Nursing Home</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>History Professor</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Howard Univ.</b>	
13a STATE <b>MD</b>	13b CITY OR TOWN <b>Washington, DC</b>	13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d STREET ADDRESS / ZIP CODE <b>654 Girard St. N.W. 20001</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Isaiah Lofton</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Whitfield</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-44-6758</b>	17 INFORMANT ADDRESS <b>Marie Lofton, 654 Girard St. N.W., Washington, DC</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Bladder Carcinoma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Yr</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Organic Brain Syndrome</b>					
19a DATE OF OPERATION <b>N/A</b>	19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>N/A</b>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <b>12/5</b> , 19 <b>80</b> , to <b>9/14</b> , 19 <b>86</b> , that (1) (we) last saw the deceased alive on <b>9/13</b> , 19 <b>86</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b SIGNATURE <b>Don H. Yablonsky</b>	DEGREE <b>MD</b>	COVERING ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>9/14/86</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don H. Yablonsky, MD</b>		22e ADDRESS <b>10300 Greenbelt Rd. #101 Seabrook, MD</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>Sept. 16, 1986</b>	23c NAME OF CEMETERY OR CREMATORY <b>J. Wm. Lee's Sons Co.</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>McGuire Funeral Service, 7400 Georgia Ave. N.W.</b>		25a DATE REC'D. BY REGISTRAR <b>SEP 25 1986</b>	25b REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

00-19688

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 3 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEATRICE E LOY			2a. DATE OF DEATH MONTH DAY YEAR SEP 24 86			2b. HOUR 3:29pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 22 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lebanon, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Looper	
						12b. KIND OF BUSINESS OR INDUSTRY Hosiery Mill	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCY BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges District Hgts							
14. FATHER'S NAME Elias		15. MOTHER'S MAIDEN NAME Jeanette		16. STREET ADDRESS ZIP CODE 2006 Tiber Drive 20747			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. SOCIAL SECURITY NO. 180 05 6832D		17c. INFORMANT ADDRESS Jeanette Toole 2006 Tiber Dr. District Hgts. 20747			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA FROM CONGESTIVE HEART FAILURE (c) <u>Pulmonary edema from congestive heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 13 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>1 September</u> 19 <u>84</u> to <u>24 September</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>24 September</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>Guy Mitchell Edmondson</u>		DEGREE MD		22c. DATE SIGNED 24 Sept 86		22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Guy Mitchell Edmondson MD		22e. ADDRESS Malcolm Grow USAF Medical Center Andrews AFB MD 20331					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-29-86		23c. NAME OF CEMETERY OR CREMATORY Grand View		23d. LOCATION CITY OR TOWN COUNTY STATE Annaville Lebanon PA	
24. FUNERAL DIRECTOR Steven R. Kreamer		ADDRESS 618 E. MAIN ST ANNVILLE, PA 17003		25a. DATE REC'D. BY REGISTRAR OCT 02 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

100-100000

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100-100000

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0-18392

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NANCY B LUKE			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1986		2b. HOUR 6:45a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Res. Manager	12b. KIND OF BUSINESS OR INDUSTRY Thomas House	
13a. STATE Maryland		13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8587 Greenbelt Road 20770
14. FATHER'S NAME FIRST MIDDLE LAST Rodney H. Baldwin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Shuck			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 180-12-4410		17. INFORMANT ADDRESS 1 Baederwood Court Linda Evans Rockville, Maryland 20855	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u> <u>4 yr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>86</u> , to <u>8-29</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8-27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Roger B. Ingham</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-30-86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER B. INGHAM		22e. ADDRESS 6510 PINEBLVD AVE, RIVERDALE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 9-7-86	23c. NAME OF CEMETERY OR CREMATORY Georgetown Med School	23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 10 1986 Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



00-19563

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must include the nature of the injury.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAUL S LYNCH			2a. DATE OF DEATH MONTH DAY YEAR SEPT 20, 86		2b. HOUR 7:04pm
3. SEX MALE	4. RACE CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR 11 11 14		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CAMP SPRINGS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcom Grow - USAF HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY MAINTENANCE	
13a. STATE Md		13b. COUNTY P.G.	13c. CITY OR TOWN Temple Hills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3411 Lumar Street 20748
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Lynch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Robert P. (son) Lynch 1705 Cadillac Circle South Melbourne, Fla 32935	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF <u>INF. LATERAL MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF <u>Inf. Lateral Myocardial Infarction</u> (c) <u>Inf. Lateral Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>7 Sept</u> , 19 <u>86</u> , to <u>20 Sept</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>20 Sept</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE CAROL A. B. RUPE Carol D.B. Rupe		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		23b. DATE SIGNED 20 Sept 86	
23c. ADDRESS MGMC		23d. ADDRESS MGMC ANDREWS AFB MD. 20331			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE XX 9-24-86	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME STATE ANATOMY BOARD		ADDRESS BALTIMORE, MD		25a. DATE REC'D. BY REGISTRAR SEP 30 1986	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

BP

00-13283

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322  
UCBAW

00-18176

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
STATE  
REGISTRAR Approved by M.E.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony John Marcoccio</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 11, 1986</b>		2b. HOUR M <b></b>
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 7, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Temple Hills</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Residence</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>City govt.</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Prince Geo.</b>	13c. CITY OR TOWN <b>Temple Hills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>8601 Temple Hills Road 20748</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Natoli Marcoccio</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Concetta unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>054-03-7696</b>	17. INFORMANT ADDRESS <b>Joseph G. Marcoccio 4700 Pelham Ct. Temple Hills, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>emphysema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b></b>					
19a. DATE OF OPERATION <b>2-7-86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (I) (the hospital) attended the deceased from <b>1-28</b> 19 <b>85</b> , to <b>9-11</b> 19 <b>86</b> , that (I) (saw) saw the deceased alive on <b>7-15</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William Kent Furst</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/11/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William K. Furst</b>		22e. ADDRESS <b>11701 Livingston Rd. # 101 Fort Washington Maryland 20744</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept 15, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Long Island Suffolk New York</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home, Inc. Clinton, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 16 1986</b>			
		25b. REGISTRAR'S SIGNATURE <b></b>			

00-16178

Completed 14 June 1964

25b. REGISTRAR'S SIGNATURE  
*Julia Davidson-Ross*







00-19538

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH-16 50M 7/73  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 1 3 8	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES M. MARSH						2a. DATE OF DEATH MONTH DAY YEAR September 23, 1986		2b. HOUR 11:45A. M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 4, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Engineer		12b. KIND OF BUSINESS OR INDUSTRY State			
13a. STATE Florida		13b. COUNTY Sarasota		13c. CITY OR TOWN Nokomis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 309 Lime Drive 33555			
14. FATHER'S NAME FIRST MIDDLE LAST Harold H. Marsh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Isabella MacDonald							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-4732		17. INFORMANT Addie Marsh (Wife)		ADDRESS 309 Lime Drive Nokomis, Florida 33555					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b): <i>metastatic lung cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Altered Impulse Control</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/26/86</i> to <i>9/23/86</i> , that (I) (we) lost <i>him</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.											
22b. SIGNATURE <i>Lewis H. Dennis</i>				DEGREE				22c. DATE SIGNED <i>9/23/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.				22e. ADDRESS 831 University Blvd. E. Silver Spring, Maryland 20903							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09/26/86		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Maryland 20781						25. DATE REC'D. BY REGISTRAR SEP 29 1986					





WILLIAMS, JAMES  
JAMES WILLIAMS

WILLIAMS, JAMES

0-20252

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OF THE FOLLOWING ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 6 2 6  
REG. NO.FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>David N. Marshall</b>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9-28 1986</b>		2b. HOUR M <b>9:25</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9-12-13</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>73 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS <b>73 YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>		MD.		
10. CITY OR TOWN OF DEATH <b>Bowie</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bowie Health Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>
12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS <b>2701 Lyn Place</b>		<b>20715</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Marshall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Simonson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>286-03-1326</b>		17. INFORMANT <b>Lois W. Marshall</b>
17. ADDRESS <b>same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>9289 Acute Myocardial Infarction</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>History of contusions</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>History of contusions</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).				
19a. DATE OF OPERATION <b>History of contusions</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>9-28-86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct. 2, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>
24. FUNERAL DIRECTOR NAME <b>R. Beatty</b>		16000 Annapolis Rd. ADDRESS <b>Bowie, Maryland</b>		25a. DATE RECD. BY REGISTRAR <b>OCT 06 1986</b>
25b. REGISTRAR'S SIGNATURE <b>Davidson</b>				

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March 11

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00-17498

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner Notified - Released to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 48 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

DHMH - 16 60M 7/84  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 2 6 / 4 1

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		10:25P <sub>M</sub>	
Tania Margaret MARSHALL		September 3, 1986			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	Aug. 7 DAY 1920 YEAR	66 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Yugoslavia	USA		Prince Georges MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Lanham	Doctors Hospital		Homemaker		own home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE		13e. INSIDE CITY LIMITS?
Maryland	Prince Georges	Berwyn Hgts	8509 Paxton Court		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Francis PREVEDEN		Mary L. (unobtainable)		YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)	
17. INFORMANT		18. SOCIAL SECURITY NO.		19. DATE OF OPERATION	
Edward O. Marshall-husband (same as 13e)		188-18-7577		19a. DATE OF OPERATION	
				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Colon Carcinoma</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>dehydration, severe bowel obstruction, semi-conscious state</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. TIME OF INJURY					
HOUR A.M. MONTH DAY YEAR					
P.M. 19					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION					
CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/3, 1986, to 9/4, 1986, that (I) (we) last saw the deceased alive on 9/3/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE					
DEGREE					
22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					
22e. ADDRESS					
Leroy E. Cohen M.D.					
6201 Greenbelt Rd., College Pk., Md. 20740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		9-7-1986		Metropolitan Crematory	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		SEP 9 1986	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
CITY OR TOWN		Alexandria		COUNTY STATE	
				Virginia	



20% CUMULATIVE



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



00-15282

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 / 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NOAH Franklin Mathias			2a. DATE OF DEATH MONTH DAY YEAR 8 9 86		2b. HOUR 1115pm M						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SOUTHERN MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1203 Nolan Dr. 20850			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		14. FATHER'S NAME FIRST MIDDLE LAST Silas Mathias					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Whitmer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple infected Decubiti</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Renal failure. Diabetes - 2500 - 571</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> , 19 <i>86</i> , to <i>8/9</i> , 19 <i>86</i> , that (I) (we) first saw the deceased alive on <i>8/9</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. Morgan</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/14/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BEZAR MOSTHAN</i>						22e. ADDRESS <i>4235 26th Ave NE 20148</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 13, 1986		23c. NAME OF CEMETERY OR CREMATORY Clover Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockingham Co., Virginia					
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.						25a. DATE REC'D. BY REGISTRAR AUG 14 1986		25b. REGISTRAR'S SIGNATURE <i>David H. ...</i>			
171 Alexander Ferry Rd., Clinton, MD 20735											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

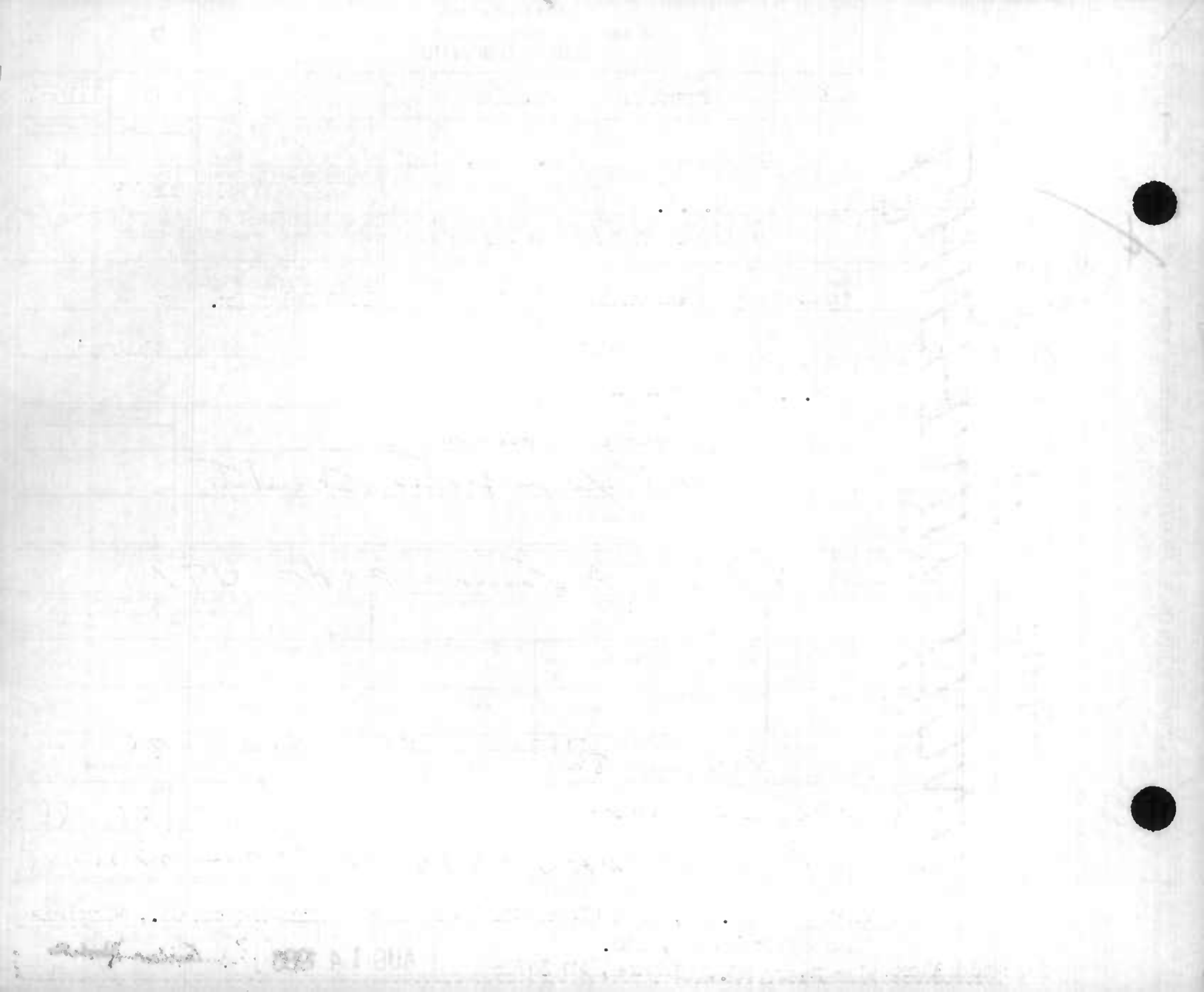
MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84

(VRA 15, 6633)

6633



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 / 4 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AGNES MATTHEWS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9-9-86</b> 2b. HOUR <b>9:16 P.</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 10 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO. MD.</b>	
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SO. MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Charwoman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Federal Govt.</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Brandywine</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Mills</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Clark</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-07-6717</b>		17. INFORMANT <b>Howard L. Matthews Sr.</b>		ADDRESS <b>13900 Tower Road Brandywine, MD 20611</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema &amp; CHF</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Decompensated Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>09-05-86</b> to <b>09-09-86</b> , that (I) (we) last saw the deceased alive on <b>09-09-86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arulhasan Ansaari</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-10-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARULHASAN ANSARI</b>		22e. ADDRESS <b>Suite 101 Clinton Md 20735</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/13/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Prince George's MD</b>	
24. FUNERAL DIRECTOR NAME <b>ROLLINS FUNERAL HOME, INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1986</b>			
ADDRESS <b>4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20015</b>				25b. REGISTRAR'S SIGNATURE <b>Jill Davidson-Randall</b>			

100-331-0

A 2.11

ON JUNE 20, 1962

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

8 6 2 6 / 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY E. MAWSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPT. 29, 1986</b>		2b. HOUR <b>10:45A</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 6, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS	7. UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VA.</b>	9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO. MD.</b>	
11. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPT.</b>		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		13b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE <b>Md.</b>			14b. COUNTY <b>P.G.C.</b>		14c. CITY OR TOWN <b>HYATTSVILLE</b>
15. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE THOMAS</b>		16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET GREEN</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		17b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-10-5389</b>		17c. INFORMANT ADDRESS <b>MABEL B. KLINE (SAME AS ITEM #13)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <b>several days</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>congestive heart failure</b>					
19a. DATE OF OPERATION <b>9/29</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18b PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> 19 <b>86</b> , to <b>9/29</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) know the body after death.					
22b. SIGNATURE <b>P. Schissler MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/30/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. SCHISLER MD</b>		22e. ADDRESS <b>7500 Greenway Ctr Dr. Greenbelt Md 20770</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-2-1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD, P.G.C. Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 08 1986</b>			
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO.</b>		24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

00-50400



Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten text, possibly a signature or date, located in the lower center of the page.

Handwritten text, possibly a signature or date, located in the lower right of the page.

Handwritten text at the bottom of the page, possibly a footer or a date.

Handwritten text at the very bottom of the page, possibly a footer or a date.

0-17771

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 1 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sylvia M. McCleaf</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>September 7 1986</b>		2b. HOUR <b>12<sup>35</sup> p.m.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 10 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co. MD.</b>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Magnolia Gardens Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Lanham</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Rentsel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie M. Musselman</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-78-7921</b>		17. INFORMANT ADDRESS <b>9409 VanBuren</b> <b>Charles L. McCleaf Lanham, MD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Circumcision**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (i) this hospital attended the deceased from <b>8/5/86</b> to <b>9/7/86</b> that (ii) (we) last saw the deceased alive on <b>9/5/86</b> and that (iii) (my) opinion death occurred on the date and hour and from the causes stated above. (If checked) did not view the body after death.			
22b. SIGNATURE <b>[Signature]</b>		22c. DATE SIGNED <b>9/7/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. Schussler MD</b>		22e. ADDRESS <b>7500 Greenway Cor Rt Crandall</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>9-8-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>
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24. FUNERAL DIRECTOR <b>Rendon Hale Lanham Funeral Home</b> <b>9013 Annapolis Rd. Lanham MD. 20706</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1986</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury or other traumatic event, the medicolegal case must be filed in one of the following offices:

BP



15771-0



00-18374

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Dallas Dexter McCormick		9 7 19 86		M	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	Black	Sept. 6, 1912	74	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
West Virginia		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cheverly		Prince George's General Hospital		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
District of Columbia		Washington		20018	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
Edward McCormick		Maggie Mitchell		2004 Perry Street, N.E.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
yes		578 07 2916		Ethel McCormick-wife- 2004 Perry St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE		M.D. Assistant		9/8/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
William M. Zane, M.D.		111 Penn St. BALTO.MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Sept. 15, 1986		Arlington National Cemetery Arlington, Va	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart Funeral Home-4001 Benning Road, N.E.		SEP 10 1986		Julia Davidson-Parker	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

48807-01



00-19850

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. FOR STATE REGISTRAR		by Med. Ex., /Gbj.		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		6		26747			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR		
COPER			McMILLAN Jr.			9 19 86			2b. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male		Black		June 20, 1953		33 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
South Carolina			United States						Prince George's County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Truck Driver					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			P. G.			Bladensburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.			17. INFORMANT		
Coper			McMillan Sr.			Alice			Anthrum		
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)			5356 Quincy Place, Bladens-			DD FORM 1		
Yes/Marines			1973/1975			212-64-4884			Debra Dinkins McMillan (wife) burg, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Thoracic trauma</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) <u></u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u></u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				12:15 PM 9-19-1986				Subject exited moving pick-up truck.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				road				5300 blk. Quincy St., Hyattsville, MD			
22a. I certify that I have viewed the remains described above, held on death resulted from				Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				Prince George's			
Actual Signature				TITLE (SPECIFY)				DATE SIGNED			
Charles P. Kokes, M.D.				M.D. Assistant				9-19-86			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Charles P. Kokes, M.D.				111 Penn St., Balto., MD				21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				09/25/86		Harmony Memorial Park				Landover, P.G.Co. Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
LATNEY's Funeral Home				OCT 03 1986				John Davidson			
3831 Georgia Ave. NW, Washington, DC 20011											

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25MBP  
DHMH - 17  
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1944-10-10



00-19247

STATE OF MARYLAND

8 6 26 / 48

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

David Edward McNeil

2a. DATE KNOWN OF DEATH MATED ☒ MONTH DAY YEAR 9-25-86 2b. HOUR M

3. SEX Male

4. RACE Black

5. DATE OF BIRTH MONTH DAY YEAR July 17, 1943

6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD 9-25-86 1986 2d. HOUR M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges Co. MD.

10. CITY OR TOWN OF DEATH

Cheverly, Md.

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Prince Georges General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK MOST OF WORKING LIFE)

Unemployed

12b. KIND OF BUSINESS OR INDUSTRY

None

13a. STATE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Prince Georges Co. Seat Pleasant

13c. CITY OR TOWN

Seat Pleasant

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 6209 Addison Road

20743

14. FATHER'S NAME

Edward

MIDDLE

LAST

McNeil

15. MOTHER'S MAIDEN NAME

Fleetia

MIDDLE

Beatrice

LAST

Vann

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

579-56-4904

17. INFORMANT

Fleetia B. Brown, Mother, Durham, N.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiomyopathy

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

Ethylium

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED 9-25-86

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct, Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

October 3, 1986

23c. NAME OF CEMETERY OR CREMATORY

Harmony Memorial Park, Landover, Prince George, Md.

23d. LOCATION CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR NAME

Bacon Funeral Home, 3447-14th Street, N.W. Washington, D.C.

25a. DATE REC'D. BY REGISTRAR

SEP 29 1986

25b. REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

D7/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

8245-9

00-17360

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 7 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM H. MEAD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-4-86</b>		2b. HOUR MIN. <b>10-15P</b>	
3 SEX <b>MALE</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>September 24, 1897</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cleveland, Ohio</b>	9b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES'</b> MD.		
10 CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Program Job Spec.</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HEW Govt.</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>P. G.</b>	13c CITY OR TOWN <b>Upper Marlboro</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Walter Mead</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Clemence</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17 INFORMANT ADDRESS <b>Richard R. Erdley Same as 13 A-E</b>		

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) move the body after death.					
22b SIGNATURE <i>Laxmi N. Berwa</i>		DEGREE <b>MD</b>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAXMI N. BERWA, M.D.</b>		22e ADDRESS <b>13000 Merchantile Lane, Largo, Md. 20772</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b DATE <b>09/05/86</b>	23c NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Prince Georges Md</b>
24 FUNERAL DIRECTOR NAME ADDRESS <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md 20735</b>		25a DATE REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <b>SEP 8 1986</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner should be notified.

00-11380

20% COTTON FIBER

WIND



5  
00-19813

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. DATE PRONOUNCED DEAD		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY		MIDDLE P.		LAST MENENDEZ		9-25 1986	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.				
F	WHITE	10-2-1941	44 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
GA.	U.S.A.				Prince George's County, MD.				
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Ft. Washington		12000 blk. Old Fort Road		EX. SEC.		THOMAS FISKE			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS			
VA. FAIRFAX						4714 CARTERWOOD DR.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
JAMES B. JOLLY		LUCILLE CHRISTIAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		266-64-4093		ERNEST MACO MENENDEZ JR.		SNAKE IS 13C			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
XX		? P.M. 9-25 1986		occupant on motorcycle that struck trees					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		road		12000 blk. Old Fort Rd., Ft. Wash., Prince					
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>		George's Co., Md.					
death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		TITLE (SPECIFY)		Assistant MEDICAL EXAMINER					
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		9-30-86		NEW HOPE CEM.		LEON CO. FLOR.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
CAPITOL FUNERAL SER.		OCT 01 1986							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. BETWEEN PAGE 5 AND YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

99999  
DHWH 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

RECEIVED

11/10/10

11/10/10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>COLLEEN MERSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9 8 86</b>		2b. HOUR <b>10: M</b>		
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 20 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.			
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater-Laurel-Beltsville Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9302 Madison Ave. 20707</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Garfield Curry</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Keeney</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578-24-2164</b>		17. INFORMANT NAME ADDRESS <b>Lois Sparks Rt 2 Box 300 Campobello, South Carolina 29322</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTROMECHANICAL DISLOCATION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS, OBESITY, HYPERCHOLESTEROLEMIA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9 8 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/8 86</b> , to <b>9/8 86</b> , that (I) (we) last saw the deceased alive on <b>9/8 86</b> , and that in (my) (our) opinion death occurred on the date and hour stated from the causes stated above, (I) (we) signed and sealed this body of death.									
22b. SIGNATURE <b>E. Smachado</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9/8/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESMACHADO</b>				22e. ADDRESS <b>321 PRINCE GEORGE ST</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>burial</b>		23b. DATE <b>Sept 11, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION <b>Brentwood Maryland</b>		STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donaldson Funeral Home P.A. Laurel, Maryland</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

00-18036

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Fred Michel</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 3, 1986</b>			2b. HOUR <b>3:30A.M.</b>				
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>dec. 9 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's MD.</b>				
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Jessup</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8104 Savage-Guilford rd. 21104</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Michel</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise ?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>0002 215-44-8488</b>		17. INFORMANT <b>Hazel Michel</b>		ADDRESS <b>same as above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8-28-86</b> 19 <b>86</b> , to <b>9-3</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>9-2</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. Jalal Fatemi</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9-3-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jalal Fatemi</b>			22e. ADDRESS <b>5632 Annapolis Rd #12 Blackensville Md. 20710</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>			23b. DATE <b>sep. 3, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Donaldson Fun. Home</b>			ADDRESS <b>313 Talbot Ave. Laurel Md.</b>			25. YEAR RECEIVED BY REGISTRAR <b>SEP 09 1986</b>				

00-10032

251 0 9 32

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 5 3

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Nicole Dod Milbourn			2a. DATE OF DEATH MONTH DAY YEAR Sept. 21 1986			2b. HOUR 2:30 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23 1938		6. AGE (IN YEARS LAST BIRTHDAY) 48		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10. CITY OR TOWN OF DEATH University Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6607 Wells Parkway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Opthamologist Asst.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b. COUNTY Prince Georges Univ. Park		13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6607 Wells Parkway 20782	
14. FATHER'S NAME FIRST MIDDLE LAST A. Bayard Dod					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Kathryn Stover					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) N/A			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Jerry R. Milbourn, Jr. (same as 13e)					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Gastrointestinal hemorrhage

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

few days

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Adenocarcinoma of liver 15 mos.

DUE TO, OR AS A CONSEQUENCE OF

(c) Adenocarcinoma of Colon 22 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 1985 to 9/21 1986 that (I) lost saw the deceased alive on 9/21 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Leonard Gold, MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Leonard Gold, MD.				22e. ADDRESS 8630 Fenton St., Silver Spring, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-1986		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 22 1986	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. The medical examiner will be notified of any death with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of any death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of any death.

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00-17595

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or regional interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RALPH Emmett MINDER, SR</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9 7 86</b>			2b. HOUR <b>10<sup>02</sup> A M</b>					
3. SEX <b>Male M</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 / 1 / 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.							
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance Chief</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>8621 Woodyard Rd. 20735</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adolf Minder</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Schlosser</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WWII</b>					16b. SOCIAL SECURITY NO. <b>578-03-5346</b>		17. INFORMANT <b>Madeline E. Minder</b>					ADDRESS <b>Same as 13 A-E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia, possibly viral</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Coronary artery disease with 3 previous infarctions</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) this hospital attended the deceased from <b>Sept 2</b> , 19 <b>86</b> , to <b>Sept 7</b> , 19 <b>86</b> , that (b) (we) last saw the deceased alive on <b>Sept 6</b> , 19 <b>86</b> , and that in (c) (my) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Ronald Landman MD</b>					DEGREE <b>MD</b>					22c. DATE SIGNED <b>9/7/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Landman MD</b>					22e. ADDRESS <b>9440 Pennsylvania Ave. Upper Marlboro Md</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>09/10/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Suitland Prince George's Md</b>					
24. FUNERAL DIRECTOR <b>Lee Funeral Home, Inc.</b> NAME ADDRESS <b>6633 Old Alexander Ferry Rd Clinton, Md 20735</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1986</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Haddell</b>						

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GARY LEE Modes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>08 04</b>		2b. HOUR <b>2:04 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 30 57</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>35</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co. MD.</b>				
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel Beltsville Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PAINTER</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Howard</b> 13c. CITY OR TOWN <b>Laurel</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD MODES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred A. MARSDON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>212-64-0868</b>		17. INFORMANT ADDRESS <b>589 GUINTANA ST. MILDRED SUPER SHIPLEY, FLA</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION, DIABETES MELLITUS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>OBESITY, VENTRICULAR ARRHYTHMIA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/4/86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/4/86</b> to <b>8/4/86</b> , that (I) (we) last saw the deceased alive on <b>8/4/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Arvind M. Mehta</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/4/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARVIND M. MEHTA</b>		22e. ADDRESS <b>7100 BALTIMORE AVE COLLEGE PARK MD</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE IF) <b>CREMATION</b>		23b. DATE <b>AUG 7, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>DONALDSON FUNERAL HOME MD</b>				
25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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FIND BATHING

Western Man C

0-17904

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 5 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice M. Montgomery			2a. DATE OF DEATH MONTH DAY YEAR September 7, 1986		2b. HOUR 8 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
10. CITY OR TOWN OF DEATH New Carrollton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5907 Westbrook Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY Prince Geo.		13c. CITY OR TOWN New Carrollton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5907 Westbrook Drive 20784								

14. FATHER'S NAME William Lang Robertson		15. MOTHER'S MAIDEN NAME Sarah Storer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 185-10-7219D	
17. INFORMANT Alice J. Kelley (Daughter)		ADDRESS Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Kidney</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>77</u> , to <u>9/7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>8-19-</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Roger B. Ingham</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-8-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger B. Ingham, M.D.		22e. ADDRESS #2400 6510 Kenilworth Ave., Riverdale, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 09/10/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
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24. FRANCIS CASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 15 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	
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00-19588

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 5 /

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Daisy T. MORRIS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>September 17, 1986</b>			2b HOUR AM <b>10:25 M</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 22, 1906</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10 CITY OR TOWN OF DEATH <b>Bowie</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10921 Maiden Drive</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. George's</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Tillery</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Jones</b>			13e STREET ADDRESS / ZIP CODE <b>10921 Maiden Drive 20715</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>239-06-1721</b>			17 INFORMANT ADDRESS <b>Earline M. Travis 10921 Maiden Drive Bowie, MD 20715</b>			

II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>		<b>10 YEARS</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEART BLOCK - ARTIFICIAL PACEMAKER</b>		<b>5 YEARS</b>	

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (the hospital) attended the deceased from <b>10-24</b> , 19 <b>85</b> , to <b>9-17</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-7</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>John Cosma MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>SEPT 17, 1986</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. John Cosma, M. D.</b>		22e ADDRESS <b>Suite 121 14300 Gallant Fox Lane Bowie, MD 20715</b>					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Burial</b>		23b DATE <b>SEPT 20, 1986</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ahoskie Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Ahoskie, Hertford, North Carolina</b>	
24 FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>		16000 Annapolis Road Bowie, MD 20715-3043		25a DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>		25b REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) EDWARD RAYMOND MOSCATI, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 09 17 86		2b. HOUR 10:57P <sup>M</sup>			
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Electrician		12b. KIND OF BUSINESS OR INDUSTRY I.B.E.W.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY P.G.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Moscati					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Rawlett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-03-0436		17. INFORMANT Address Address Same as Edward R. Moscati, Jr. No# 13.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>None</u> <u>4 yrs</u> <u>4 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF YES, NOTIFY MEDICAL EXAMINER)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15</u> 19 <u>86</u> to <u>9/17</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>9/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE		22c. DATE SIGNED <u>9/19/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD A. ANSWELL, MD</u>					22e. ADDRESS <u>P.G. Hospital Cardiovascular Division</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/22/86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland					25a. DATE REC'D. BY REGISTRAR SEP 25 1986					
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>										

44A  
44B

44C

00-20044

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM D. MULROONEY			2a. DATE OF DEATH MONTH DAY YEAR 09-30-86			2b. HOUR 2:30PM M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9-18-1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Gas Co.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Bladensburg									
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Mulrooney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hunter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2		17. INFORMANT ADDRESS Mrs. Laura Mulrooney, Same as Line #13					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Intermittent Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29</u> 19 <u>86</u> to <u>Oct 29</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Benjamin S. Pecson</u>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <u>Oct 1, 1986</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin S. Pecson				22f. ADDRESS 6106 Silver Hill Rd., Forestville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-3-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland			
24. FUNERAL DIRECTOR'S NAME FRANCIS CASCH, SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 06 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

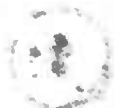
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Warrant, Jackson  
Columbus, Ohio, March 1900

*[Handwritten signature]*  
for  
the  
of

on 1900  
for the  
of

00-19666

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 6 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen Catherine Murray</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 - 26 - 86</b>			2b. HOUR <b>3:45AM</b>					
3. SEX <b>F</b> Female		4. RACE <b>W</b> White		5. DATE OF BIRTH MONTH DAY YEAR <b>1 - 08 - 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Largo Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor-Care Largo</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PEPCO</b>			
13a. STATE <b>Florida</b>			13b. COUNTY		13c. CITY OR TOWN <b>Clearwater</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2563 Ramblewood Dr. 33515</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Hamlin Staub</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie Cecelia Colburn</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>571-05-0213</b>	
17. INFORMANT <b>A. William Blake Jr</b>			ADDRESS <b>607 West Bayfront Road</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Recurrent wrosepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colon bladder fistula</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 7</b> , 19 <b>86</b> , to <b>SEP 26</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Villamor S. Reyes M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/26/86</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VILLAMOR S. REYES, M.D.</b>						22e. ADDRESS <b>6501 Landover Rd, Cheverly MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>29 Sept 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>				
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Frederick J. ...</b>			
4308 Suitland Road, Suitland, Maryland						OCT 01 1986					

DHMH - 46 60M 7/84

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 above any injury, or other traumatic event, the medical examiner must be notified of this.



00-19937

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 4 and 5 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 should only injury, or other traumatic event, the death certificate must be notified to the coroner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 / 6 1	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robin Marie Murtagh					2a. DATE OF DEATH MONTH DAY YEAR September 27, 1986			2b. HOUR 1:00 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5-12-60		6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6112 40th Avenue 20782			
14. FATHER'S NAME FIRST MIDDLE LAST James Oroian					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Hackney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 217-80-1643		17. INFORMANT ADDRESS Donald Murtagh, Same as Line #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Malignant</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (1) (this hospital) attended the deceased from <u>15 April 1986</u> to <u>29 Sept 86</u> , that (1) (we) lost <u>the deceased</u> (due to the death of the body after death) and that in my (our) opinion death occurred on the date and hour and from the causes stated											
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger										22b. ADDRESS 7525 Greenway Cir Drive Greenbelt MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-30-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood, P.C., Maryland 20770			
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR OCT 03 1986					

BP





0-17067

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
HORACE W. MYERS				09 02 86		5:00 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Caucasian		May 4, 1905		81		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maine		U.S.A.				PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF WORK FOR OTHER THAN USUAL, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY			
CLINTON		Southern Md Hospital		Govt. Services		Federal Govt.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
Maryland		P. G.		Temple Hills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4025 28th Avenue 20748	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Johnathan W. Myers		Mary Eleanor Morrison		Yes		1925-1928		Stella P. Myers Same as 13A-E	
18. CAUSE OF DEATH (Enter only one cause per line or (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Bilateral Pneumonia				Chronic Hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1986, 19, to 9/2, 1986, that (we) lost		22b. SIGNATURE		22c. DATE SIGNED					
saw the deceased alive on 9/2, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (type) (did) (did not) see the body after death.		G.D. WATKINS		9/3/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE			
G.D. WATKINS		WATKINS, W.D.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		09/05/86		Maryland Veterans Cem.		Cheltenham P.G. Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Funeral Home, Inc.		Old Alexander Ferry Rd. Clinton, Md 20735		SEP 5 1986					

DHMH - 16 60M 7/84

(VRA 15, 4)

6633

0-15081

0-18872

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 6 / 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Einar Tarval Neilsen			2a. DATE OF DEATH MONTH DAY YEAR September 21, 1986		2b. HOUR 12:30AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. MONTHS DAYS HRS. MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) Denmark		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Silver Hill Con. Co.	
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) Christian Anderson			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Marian Unk.			13e. STREET ADDRESS / ZIP CODE 8110 Bock Road 20744		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Anna M. Sommers		ADDRESS 7412 Leona St. Forestville, Md 20747		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cancer of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary tract sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>86</u> , to <u>9/21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Brooks Dickerson, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. BROOKS DICKERSON				22e. ADDRESS 6188 OXON HILL ROAD, OXON HILL MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09/23/86		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Maryland		
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE		
6633 Old Alexander Ferry Road Clinton, Md 20735								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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-18434

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST ISABELLE MIDDLE M. LAST NELSON <i>ISABELLE M NELSON</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Sept 1 86</i>					2b. HOUR <i>830 P M</i>
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCTOBER 25, 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		9. CITIZEN OF WHAT COUNTRY? <b>United States</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES MD.</b>				
12. CITY OR TOWN OF DEATH <b>LINTON</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		15. KIND OF BUSINESS OR INDUSTRY <b>private</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Marlow Hts</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4356 23rd Place 20748</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Young</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578 66 5984-T</b>		17. INFORMANT ADDRESS <b>Horace Nelson-son-1331 28th St SE Wash DC</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe BRAL Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Renal failure, BRONCHOPNEUMONIA, URINARY TRACT INFECTION, HYPERTENSION, Diabetes</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1986</b> , to <b>Sept 1, 1986</b> , that (I) (we) lost saw the deceased alive on <b>Sept 1, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Helen Capone MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>Sept 2-1986</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Helen Diana CAPONE MD</b>				22e. ADDRESS <b>7501 SACRATTS Rd Chn Dn Md 20735</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/5/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEMORIAL CEM</b>		23d. LOCATION STREET CITY OR TOWN COUNTY STATE <b>SUITLAND, PG MARYLAND</b>				
24. FUNERAL DIRECTOR NAME <b>ALEXANDER S. POPE</b>				ADDRESS <b>2617 PA AVE., SE WASH, DC</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

BP



00-18744

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100. A SEPARATE PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6 26165	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Philip C NELSON</i>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>9-19 1986</i>	
3. SEX <i>Male</i> 4. RACE <i>Caucasian</i> 5. DATE OF BIRTH MONTH DAY YEAR <i>12-17-21</i> 6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.										2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>9-19 1986</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Michigan</i> 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southern Maryland Hospital</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Exchange Repairman</i>	
11. CITY OR TOWN OF DEATH <i>Cheverly</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>Telephone</i>	
13a. STATE <i>Maryland</i> 13b. COUNTY <i>Charles</i> 13c. CITY OR TOWN <i>Waldorf</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>4041 Parker Court 20601</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Eric Nelson</i>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Crowley</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> (IF YES, GIVE WAR OR DATES) <i>WW II</i>										16b. SOCIAL SECURITY NO. <i>372 12 8217</i>	
17. INFORMANT ADDRESS <i>Angeline Nelson (Wife) same as #13</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19a. DATE OF OPERATION										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> TITLE (SPECIFY) <i>Deputy</i> M.D. MEDICAL EXAMINER										DATE SIGNED <i>9-19-86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i> ADDRESS <i>5009 Rayburn Ct., Temple Hills, MD</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>(9-23-86)</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Riverside Cemetery</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>Ironwood, Minnesota</i>	
24. FUNERAL DIRECTOR'S NAME <i>James-Pearson FH Arlington, Va. 22201</i>										25a. DATE REC'D. BY REGISTRAR <i>SEP 22 1986</i>	
25b. REGISTRAR'S SIGNATURE											

MEDICAL CERTIFICATION

Page 2 of 10

10-1-10

10-1-10

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10-1-10



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00-16444

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FRED G. NEWCOMB		2a. DATE OF DEATH 8-21-86	
2. SEX M Male		2b. HOUR 0600	
3. RACE Caucasian		3. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
4. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		4. DATE OF BIRTH 8 23 31	
5. CITIZEN OF WHAT COUNTRY? USA		5. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
6. CITY OR TOWN OF DEATH CLINTON		6. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
7. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Maryland		7. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Southern Maryland Hosp Ctr	
8. COUNTY Charles		8. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military	
9. CITY OR TOWN Waldorf		9. KIND OF BUSINESS OR INDUSTRY USGov	
10. FATHER'S NAME FIRST MIDDLE LAST Frederick William Newcomb		10. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Weilbacher	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		11. SOCIAL SECURITY NO. 1952-1974 299-28-6808	
12. INFORMANT Alice Marie Newcomb		12. ADDRESS -same as #13-	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>meningoencephalitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bacterial Endocarditis Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Renal Failure, Uremia, Congestive Heart Failure, Abdom. aneurysm, GI bleed.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
14. DATE OF OPERATION		14. CONDITION FOR WHICH OPERATION WAS PERFORMED	
15. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		15. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
16. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		16. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
17. INJURY OCCURRED		17. LOCATION STREET CITY OR TOWN COUNTY STATE	
18. I certify that (I) (the hospital) attended the deceased from <u>8/23</u> 19 <u>86</u> , to <u>8/24</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>8/24</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.		18. DATE OF OPERATION	
19. SIGNATURE <u>R. A. McConaughy</u> M.D.		19. DEGREE M.D.	
20. PHYSICIAN'S NAME (TYPE OR PRINT) R. A. McConaughy, M.D.		20. ADDRESS 5618 St. Barnabas Rd., Oxon Hill, Md.	
21. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		21. DATE NAVAL ASSGN.	
22. NAME OF CEMETERY OR CREMATORY Atlantic Ocean		22. LOCATION CITY OR TOWN COUNTY STATE At Sea Atlantic Ocean	
23. FUNERAL DIRECTOR NAME Hunt Funeral Home		23. ADDRESS P. O. Box 156 Waldorf, Md 20601	
24. DATE REC'D. BY REGISTRAR AUG 27 1986		24. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

8-11-86



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

26768

1- FOR  
STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Drane</i>		MIDDLE <i>Cassandra</i>		LAST <i>Niedzinski</i>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 9-24-86		2b. HOUR 1986	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept 20 1955</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>31</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>9-25-86</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Suitland</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5264 Belgreen St. 403</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Marketing Representative</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>PR George</i>		13c. CITY OR TOWN <i>Suitland</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5204 Belgreen St 20746</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter Niedzinski</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Dusky</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>137-52-6171</i>		17. INFORMANT <i>Helen Niedzinski</i>		ADDRESS <i>309 Washington AV Nutley, N.J.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Seizure disorder</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>Ethylisms</i> (b) <i>Ethylisms</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Pancreatitis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>9-25-86</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>		ADDRESS <i>5009 Rayburn Ct, Temple Hills, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>29 Sept 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glendale Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bloomfield Essex N.J.</i>					
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>		FUNERAL HOME <i>Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
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(VR A15 ME (5))

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26169

1- STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Takahashi, N. Noda			2a. DATE KNOWN OF DEATH MONTH DAY YEAR Sept 24 1986			2b. HOUR OF ESTI. DEATH MATED 5:55 PM		
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Aug 4 1967	6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Sept 24 1986	7d. HOUR 5:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hawaii	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Docters Hosp. PC			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist	12b. KIND OF BUSINESS OR INDUSTRY Dentistry			
13a. STATE Md			13b. COUNTY Prince Georges	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2411 Radcliffe Dr		
14. FATHER'S NAME FIRST MIDDLE LAST Yasuo Noda			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maru Kinoshita					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 576-07-1697		17. INFORMANT Marie A. Noda			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE John S. Rogers			TITLE (SPECIFY) M.D. Dep.			DATE SIGNED Sept 25 1986		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers			ADDRESS 1919 Seminary Road, Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Sept 29 1986		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Beall Funeral Home			ADDRESS 16000 Annapolis Rd. Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 29 1986			
25b. REGISTRAR'S SIGNATURE								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



4881 NOTED 1960

WALKER

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Kiln", "Mater", "Yarn", "Stout", "Kiln", "Mater", "Yarn" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Francis NOLAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>September 18, 1986</b>					
3. SEX <b>male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 1 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7b. HOUR <b>5:05 A.M.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>A.M.I. Doctors' Hospital of P.G.Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone</b>		
13a. STATE <b>Florida</b>		13b. COUNTY <b>Charlotte</b>		13c. CITY OR TOWN <b>Puntagorga</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11292 Royale Rd. 33955</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Nolan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Brady</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>188100053</b>		17. INFORMANT <b>1910 County Rd. #103 Faye McBrayer District Heights, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon metastatic</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Cervicomech, Spastic, Acidosis, respiratory failure</b>										
19a. DATE OF OPERATION <b>8/25/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinomatous</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/25</b> , 19 <b>86</b> , to <b>9/18</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>9/15</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Frederick H. Wilhelm M.D.</b>				DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>9/18/86</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDERICK H. WILHELM, M.D.</b>				22e. ADDRESS <b>5407 Annapolis Road Huntville, Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/22/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clark Union N.J.</b>				
24. FUNERAL DIRECTOR NAME <b>FLECK FUNERAL HOME Inc.</b>				ADDRESS <b>2601 Sandy Spring Road, Laurel, Md.</b>		DATE REC'D. BY REGISTRAR <b>SEP 22 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick H. Wilhelm</b>		

70781-00

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 7 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Manuel Edward Nunes			2a. DATE OF DEATH MONTH DAY YEAR September 21, 1986			2b. HOUR 6 <sup>25</sup> A <sup>M</sup>					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 6, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher			12b. KIND OF BUSINESS OR INDUSTRY Board of Ed.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Prince Geo.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6100 Westchester Pk. Dr., #13 20740	
14. FATHER'S NAME FIRST MIDDLE LAST Manuel (NMI) Nunes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ermelinda Carreira							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW-2		17. INFORMANT ADDRESS Margery E. Nunes, Same as Line #13					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Arteriosclerotic Cardio-vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes Mellitus, Type II - Insulin dependent</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, OR CONDITION GIVEN IN PART 1 (1):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 80 9/4/86 80 0					
22a. I certify that (1) (this hospital) attended the deceased from <i>Sept 23, 1986</i> to <i>9/21/86</i> , that (1) (we) last saw the deceased alive on <i>9/21/86</i> and that (1) (our) opinion of death occurred on the date and hour and from the causes stated above. I have not seen the body after death.											
22b. SIGNATURE <i>William D. Rosson</i>						22c. DATE SIGNED 9-22-86			22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Rosson, M.D.		
22e. ADDRESS 5701 85th Ave., New Carrollton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9-24-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Maryland			
24. FUNERAL HOME NAME 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 25 1986		25b. REGISTRAR'S SIGNATURE <i>William D. Rosson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 6 1 7 2	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>MARGUERITE</b>			FIRST MIDDLE LAST <b>NUNEZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-5-86</b>			2b. HOUR <b>0036M</b>		
3. SEX <b>F</b>		4. RACE <b>in Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 03 14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WAH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Prince Geo.</b> 13d. CITY OR TOWN <b>Takoma Park</b> 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13f. STREET ADDRESS / ZIP CODE <b>48 Sherman Ave. 20912</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lambert D. Herman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate B. Arenburg</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>012-09-8759</b>		17. INFORMANT ADDRESS <b>Albert Nunez 48 Sherman Ave. Takoma Pk. Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/2/86</b> 19____, to <b>5/5/86</b> 19____, that (I) (we) lost saw the deceased alive on <b>5/3</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Kirkland C. Brace</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>5/5/86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kirkland C. Brace</b>			22e. ADDRESS <b>17600 Carroll Ave Takoma Pk.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>5/6/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Howard U. Med. School</b>		23d. LOCATION CITY OR TOWN <b>Washington</b> COUNTY <b>D. C.</b> STATE				
24. FUNERAL DIRECTOR <b>Sam Butler Funeral Ser. 716 Kennedy St. N.W. Washington, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1986</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

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00-18733

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 1 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN W. O'NEAL			2a. DATE OF DEATH MONTH DAY YEAR 9-15-86			2b. HOUR 9:50 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 19 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES Co. MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police officer		12b. KIND OF BUSINESS OR INDUSTRY MPD		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Pr George		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Eugene O'Neal			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Purvis			16. STREET ADDRESS / ZIP CODE 6890 Briscoe Turn R John Wayne O'Neal Owings, Md/				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.		17. INFORMANT John Wayne O'Neal Owings, Md/				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBROVASCULAR DISEASE										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9:15 to 9:15, 1986, that (I) (we) lost saw the deceased alive on 9:15 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE SAWALLM			DEGREE			22c. DATE SIGNED 9/16/86		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) GURBUX NACHHANI			22f. ADDRESS 8926 WOODYARD RD. 20735 MD CLINTON							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 18 Sept 86		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home					25a. DATE REC'D. BY REGISTRAR SEP 22 1986		25b. REGISTRAR'S SIGNATURE			

00-18733

100% COTTON FIBER



0-17205

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MILDRED M. ORANGE			2a. DATE OF DEATH MONTH DAY YEAR 09 01 86			2b. HOUR 6:46 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 19 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE Maryland			13b. COUNTY Prince George Clinton		13c. CITY OR TOWN CLINTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6807 Fulford St. 20735	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Charles Braugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Mary Eyring							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-22-0582		17. INFORMANT ADDRESS Francis J. Orange 6807 Fulford St. Clinton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 96 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> , 19 <u>86</u> , to <u>9/1</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>9/1</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE William Kent Furst MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/2/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. FURST M.D.			22e. ADDRESS 11701 Livingston Rd. Ft. Wash. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/5/86		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Maryland			
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home			6160 Oxon Hill Rd. Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR SEP 5 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 allows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



00-18985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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25M

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DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SIDNEY PALMER</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 17 1986</b>			2b. HOUR <b>6:15 PM</b>		
1. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 1 1921</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>65</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 17 1986</b>	7d. HOUR <b>6:15 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Jamaica</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.		
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Leland Memorial Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed/Janitor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. CITY OR TOWN <b>PRINCE GEORGE'S MOUNT RAINIER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3201 BUNKER HILL RD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jessie Palmer</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lea Nicholson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-88-8401</b>		17. INFORMANT ADDRESS <b>Lucy Palmer (wife) 3201 BUNKER HILL RD, MOUNT RAINIER, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to, immediate cause (a) stating the underlying cause last: (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Diabetes Mellitus, seizure disorder</b>								
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>N/A</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Paul A. DeVore</b>		TITLE (SPECIFY) <b>M.D. Deputy</b>		DATE SIGNED <b>9/17/86</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Paul A. DeVore</b>		ADDRESS <b>4203 C. Queensbury Rd, Hyattsville MD 20781</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sep. 22, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Suitland Md</b>		
24. FUNERAL DIRECTOR NAME <b>F.M. Dudley &amp; Sons Funeral Home</b>		ADDRESS <b>3200 Rhode Island Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1986</b>		25b. REGISTRAR'S SIGNATURE		



00-18970

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Clifton Brook Payne</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 20 86</b>		2b. HOUR <b>12:27P.M.</b>
3. SEX <b>male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 02 10</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>Clinton, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital Ctr</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Retired Conductor Railroad</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Ft. Wash.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William W. Payne</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Ryan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579031352</b>		17. INFORMANT ADDRESS <b>Corrie Louise Payne 3608 Chandler Dr. Ft. Washington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lung Cancer</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-26</b> , 19 <b>86</b> , to <b>9-20</b> , 19 <b>86</b> , that (I) <del>have</del> lost saw the deceased alive on <b>9/20/86</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If I have not seen the body after death.)					
22b. SIGNATURE <b>Boris G. Vlalukin MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/21/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BORIS G. VLALUKIN MD</b>		22e. ADDRESS <b>9131 PISCATAWAY CLINTON Md 20735</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/24/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 23 1986</b>			
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b>		ADDRESS <b>6160 Oxon Hill Oxon Hill, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

BP



*[Faint, mostly illegible text, possibly a letter or document header. Some words like "Dear Sir" and "Yours faithfully" are visible.]*

*[Faint text at the bottom of the page, possibly a signature or footer.]*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR THE MEDICAL EXAMINER ALONG WITH FORM PM-3. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1 - STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										6 26 / 1 / 1 REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT) Ida Da Ascensao Simao Pessoa															2a. DATE KNOWN OF DEATH ESTIMATED Sept 14 1986															2b. HOUR 7:00 P.M.																			
3. SEX Female					4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR June 29, 1923					6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.					7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.					7c. IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD Sept 14 1986					2d. HOUR 7:00 P.M.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Portugal										7b. CITIZEN OF WHAT COUNTRY? Portugal										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County																			
10. CITY OR TOWN OF DEATH Riverdale										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Own Home																			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland 113b. COUNTY										13c. CITY OR TOWN P.G. Hyattsville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 4900 49th Avenue 20781																			
14. FATHER'S NAME FIRST MIDDLE LAST Francisco Simao										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emilia Da Ascensao										16. IF WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 217-98-1877										17. INFORMANT (Husband) ADDRESS 4900 49th Avenue Jose Da Silva Pessoa Hyattsville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <u>Chronic Myocardial Disease</u> (b) <u>Chronic Myocardial Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>None</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
19a. DATE OF OPERATION <u>None</u>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE <u>John S. Rogers</u>										TITLE (SPECIFY) M.D. <u>Dope</u>										MEDICAL EXAMINER DATE SIGNED Sept 14 1986																													
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										ADDRESS 1919 Seminary Rd. Silver Spring, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 09/22/86										23c. NAME OF CEMETERY OR CREMATORY Cemetery of Alfeizerao										23d. LOCATION CITY OR TOWN COUNTY STATE Alfeizerao Alcobaca Portugal																			
24. FUNERAL DIRECTOR NAME Francis Casch's Sons Funeral Home, P.A.										ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781										25a. DATE REC'D. BY REGISTRAR SEP 15 1986										25b. REGISTRAR'S SIGNATURE <u>John S. Rogers</u>																			



RECEIVED XEROX

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*



00-19070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 2 6 / 1 8	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST ELIZABETH Ann PETZOLD					MONTH DAY YEAR SEPTEMBER 20, 1986					5:10 am	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec 30, 1994			6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD				
10. CITY OR TOWN OF DEATH Andrews A.F.B.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland					13b. CITY OR TOWN Charles		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Rt-232 Box-2428 / 20601		
14. FATHER'S NAME FIRST MIDDLE LAST Heinrich Munach					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unavailable						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - 213-74-7972		17. INFORMANT ADDRESS Martha E. Robinson (same as #13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Cerebral vascular accident</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6 Aug</u> , 19 <u>86</u> , to <u>20 Sept</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>20 Aug</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bonnie L. Burnquist, MD</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>20 Sept 86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Bonnie L. Burnquist, MD</u>					22e. ADDRESS MALCOLM GROW MEDICAL CTR, AAFB, MD. 20331						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md.			
24. FUNERAL DIRECTOR NAME Hunt Funeral Home			P. O. Box 156 Waldorf, Md 20601			25a. DATE REC'D. BY REGISTRAR SEP 24 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Dinkon-Randall</u>			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 / 1 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

00-18445

1. DECEASED NAME (TYPE OR PRINT) <b>RACHEL V. Phillips</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>09-15-86</b>		2b. HOUR <b>3:20p.m.</b>
3. SEX <b>F</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 7 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County</b>
10. CITY OR TOWN OF DEATH <b>Adelphi</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presidential Woods Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>teacher</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Prince Geo. Co.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Prince Georges Hyattsville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fred Cleveland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lizzie Soule</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-36-9248</b>	17. INFORMANT <b>son</b> <b>605 Overhill Drive</b> <b>Fred Phillips Edgewater, Md. 21037</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Obstructive Jaundice</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Carcinoma of the Gall bladder.</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Organic Brain Syndrome</b>				
19a. DATE OF OPERATION <b>9/13/86</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>8/19/85</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9/13/86</b> to <b>9/15/86</b> , that (I) (we) lost saw the deceased alive on <b>9/13/86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Stuart J. Turkewitz, M.D.</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/15/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stuart J. Turkewitz, M.D.</b>		22e. ADDRESS <b>7500 Greenway Center Dr. Greenbelt, Md-20770</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 19, 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Prince Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins, Jr.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>
500 University Blvd. West, Silver Spring, Md.		29901		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. 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Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

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00-17598

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

26785

1- STATE REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME  
(TYPE OR PRINT)

Charles Michael Pickeral

Charles M. Pickeral

2a. DATE KNOWN OF DEATH  
OF ESTI- MATED ☒ 9-8 1986

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

July 15, 1956

6. AGE (IN YEARS)

30 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD

9-8 1986

2b. HOUR

866P

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince Georges

10. CITY OR TOWN OF DEATH

Suitland

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

4804 Eastern Lane 2072

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Cashier Cafeteria

12b. KIND OF BUSINESS OR INDUSTRY

Private

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Prince Georges

13c. CITY OR TOWN Suitland

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS

4804 Regency Sta Rd. 20747

14. FATHER'S NAME

Charles C. Pickeral

15. MOTHER'S MAIDEN NAME

Nancy McKenzie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

None

16b. SOCIAL SECURITY NO.

579-86-0124

17. INFORMANT

Mrs. Nancy A. Pickeral Palmer Park Md.

ADDRESS 2029 Ray Leonard Rd.

18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Shotgun wound to the head.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR  
P.M. 9-8 1986

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Self-inflicted

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

Home

21f. LOCATION

4804 Eastern Lane, 2072, Suitland, Md

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

9-8-86

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS 5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept. 12, 1986

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION

Suitland P.G. Co. Maryland

24. FUNERAL DIRECTOR NAME

Lee Funeral Home Inc.

ADDRESS

6633 Old Alexander Ferry Road Clinton md. 20735

25a. DATE REC'D. BY REGISTRAR

SEP 10 1986

25b. REGISTRAR'S SIGNATURE

Augusto P. Rodriguez

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE DATE, TIME, AND 3 TO THE FUNERAL DIRECTOR. PAGE 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE DEATH CERTIFICATE. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 4 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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Shanghai 1941

00-18731

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6

1 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Marilyn Dere		MIDDLE PIKE		LAST PIKE		2a. DATE OF DEATH		MONTH 9		DAY 14		YEAR 86		2b. HOUR 10:51 AM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH		MONTH March		DAY 17		YEAR 1927		6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES, MD.																	
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Maryland Hospital																					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting Clerk		12b. KIND OF BUSINESS OR INDUSTRY USGov't																					
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Hillcrest Hts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4311 23rd Pkwy 20748															
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
FIRST William				MIDDLE L				LAST Dere				FIRST Bess				MIDDLE Baskeyfield				LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.				17. INFORMANT Donald J Dere															
								ADDRESS 4901 Rutland Pl Alex Va															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS</u>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>719</u> , 19 <u>86</u> , to <u>714</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>714</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>[Signature]</u>				DEGREE				22c. DATE SIGNED 9115186															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GURBUX NATHANI				22e. ADDRESS 8926 Woodyard Rd. Clinton																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 17Sept				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN Suitland PG MD											
24. FUNERAL DIRECTOR NAME Robert E Wilhelm Funeral Home				ADDRESS Suitland, Md				25a. DATE REC'D. BY REGISTRAR SEP 22 1986				25b. REGISTRAR'S SIGNATURE											

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ROYAL CANADIAN MOUNTED POLICE

TO THE CHIEF OF POLICE  
MONTREAL  
FROM THE CHIEF OF POLICE  
OTTAWA

RE: [illegible]  
[illegible]

[illegible]  
[illegible]

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VOID

CERTIFICATE # 86-26782



0-18825

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR					REG. NO. 8 6 2 6 1 8 3							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA M Potts					2a. DATE OF DEATH MONTH DAY YEAR 8-24-86					2b. HOUR 10:00 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR OCT. 22 1884		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES CO. MD.						
10. CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Marys Land Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maid		12b. KIND OF BUSINESS OR INDUSTRY Shoreham Hotel				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY P.G.		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST George - Durity					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida - unknown					13e. STREET ADDRESS / ZIP CODE 9211 Stewart La. 20735		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		16c. SOCIAL SECURITY NO. 579-12-9908		17. INFORMANT ADDRESS E. Thel Vann 9613 Ridgeway Dr Owings Md. 20736						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypovolemic &amp; Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intest. Obstruction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8-24-86 to 8-24-86, that (I) (we) last saw the deceased alive on 8-24-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE J. W. Chambers, Jr.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-25-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ABULH ASAN ANSARI				22e. ADDRESS Suite 101 8926 Woodland Rd. Clinton Md. 20735								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/25/86		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale P.G. Md.				
24. FUNERAL DIRECTOR NAME W.W. Chambers & Co.				ADDRESS 5907 Cleveland Rd. Riverdale Md. 20735				25a. DATE REC'D. BY REGISTRAR SEP 15 1986				
								25b. REGISTRAR'S SIGNATURE Davidson-Rondelli				

DIVISION OF VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

Relinquished by Dr. Robinson

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DHMH - 16 60M 7/84  
(VRA 15, 4)

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Handwritten notes and diagrams, including a large 'X' and various illegible text fragments.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, the medical officer of the health department should be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 2 6 / 8 4	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>RUH L PRESTON</b>		2a. DATE OF DEATH MONTH <b>9</b> DAY <b>25</b> YEAR <b>1986</b>		2b. HOUR <b>10:10 A.M.</b>	
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>1</b> DAY <b>14</b> YEAR <b>03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>CLINTON, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>28 SOUTHERN MARYLAND HOSP</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Temple Hills</b>	
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>M.</b> LAST <b>Stevens</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>L.</b> LAST <b>Willoughby</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-62-6964</b>		17. INFORMANT ADDRESS <b>Mary R. Hughes as in item #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SWELL</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>SEPTIC SHOCK, MULTIPLE PERFORATED COLON</b>					
19a. DATE OF OPERATION <b>8/12/86</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ceasotomy for PERFORATED COLON</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/12</b> , 19 <b>86</b> , to <b>9/26</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>9/26</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Glenn H. Funder</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. JACOB H. FINDER, MD</b>		22e. ADDRESS <b>7501 SURRATT RD, #306 CLINTON, MD 20735</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas F.H.</b>		ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>SEP 29 1986</b>	

1. Name of the person or organization to whom the letter is addressed  
2. Address of the person or organization to whom the letter is addressed  
3. City and State of the person or organization to whom the letter is addressed  
4. Zip Code of the person or organization to whom the letter is addressed

5. Date of the letter  
6. Subject of the letter  
7. Salutation of the letter  
8. Body of the letter  
9. Closing of the letter  
10. Signature of the person or organization sending the letter

11. Enclosure  
12. Postmark  
13. Return address  
14. Postage stamp  
15. Postage meter

16. Postage paid  
17. Postage prepaid  
18. Postage guaranteed  
19. Postage insured  
20. Postage registered

21. Postage meter  
22. Postage stamp  
23. Postage meter  
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40. Postage meter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 8 3

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BRYAN</b> <b>M</b> <b>Pumphrey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 27 1986</b>		2b. HOUR <b>6<sup>PM</sup></b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 6 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD		
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Magnolia Gardens Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco Authority</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>Pr Geo</b> 13c. CITY OR TOWN <b>Riverdale</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>5661 57th Avenue 20737</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Columbus Pumphrey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Condie</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-09-9018</b>		17. INFORMANT ADDRESS <b>H-C-1 Box 96 Front Royal, Va. 22630</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia aspiration.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced Parkinson's Disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Heart Disease.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>① Urinary tract infection ② Sepsis. ③ Sickle cell disorder</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNPREDICTABLE <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, ADVISE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> OUT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <b>9/26/1986</b> to <b>9/26/1986</b> , that (I) (we) last saw the deceased alive on <b>9/26/1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>S. Rudapi MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/26/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHRINIVAS R. UDAPATI</b>		22e. ADDRESS <b>6005 Landover Rd. CHEVERLY, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>30 Sept 1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Epis Ch Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Forestville PG Md</b>	
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>		24b. FUNERAL HOME <b>Suitland, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 01 1986</b>	25b. REGISTRAR'S SIGNATURE

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Handwritten notes in the middle section, possibly describing a process or experiment.



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00-17072

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26186		
1- STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT) <b>Ray Stewart</b>				2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-2 1986</b>				2c. HOUR <b>3:35</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 8, 1923</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>63 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7d. DATE PRONOUNCED DEAD <b>9-2 1986</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>			
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Andrews AF 13 Malcolm Grounds Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Civil Serv.</b>			
13a. STATE <b>Kentucky</b>			13b. CITY OR TOWN <b>Jefferson</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS <b>3312 Warren Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Carl Raines</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dixie Hocker</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 405-20-0503</b>			17. INFORMANT <b>Jimmy S. Raines</b>			ADDRESS <b>11420 Brandywine Road Clinton, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Coronary atherosclerosis</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>			TITLE (SPECIFY) <b>Deputy</b>			M.D. MEDICAL EXAMINER			DATE SIGNED <b>9-2-86</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>			ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Sept. 6, 1986</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rest haven Mem. Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Louisville Jefferson Ky.</b>			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b> ADDRESS <b>6633 Old Alexander Ferry Rd Clinton, Md.</b>						25a. DATE REGD. BY REGISTRAR <b>SEP 5 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

Handwritten notes and signatures at the top of the page, including a signature that appears to read "John F. Kennedy".

Handwritten notes and signatures in the middle section, including a signature that appears to read "Robert F. Kennedy".

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "John F. Kennedy".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 6 2 6 / 8 7

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DELLA F. RAMSBURG		2a. DATE OF DEATH MONTH DAY YEAR 08-28-86	
3. SEX female		4. RACE white	
5. DATE OF BIRTH MONTH DAY YEAR 11-08-1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY towel & linen	
13a. STATE MD		13b. COUNTY Anne Arundel	
13c. CITY OR TOWN Lothian		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 249 Edward Lane 20711			
14. FATHER'S NAME FIRST MIDDLE LAST William Keller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (nmn)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 234-01-7784	
17. INFORMANT ADDRESS Mr. Steward A. Ramsburg, Lothian, MD - husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia - Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Status post clipping of right Cerebral aneurysm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1984</u> , 19 <u>84</u> , to <u>8/27</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>8/27/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Robert J. Gereige MD</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GEREIGE		22e. ADDRESS 4410 74th Ave Landover MD 20784	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-31-1986	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		25a. DATE REC'D. BY REGISTRAR SEP 02 1986	
		25b. REGISTRAR'S SIGNATURE <u>Julia D. Rader</u>	

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80-18502

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REID A. RAWLINS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9-15-86</b>		2b. HOUR <b>3:40 AM</b>
3. SEX <b>M Male</b>	4. RACE <b>W White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7-4-09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges Co MD.</b>
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SO. MARY LAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Calvert</b>	13c. CITY OR TOWN <b>Prince Frederick</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS / ZIP CODE <b>Box 37 20678</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Rawlings</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida E. Scrivener</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-28-9921</b>		17. INFORMANT ADDRESS <b>Ida Mae Cunningham XXX same as #13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF PROSTATE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>8-25-86</b> , 19 <b>86</b> , to <b>9-15</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>9-14-86</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Krishan N. Mathur MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHAN MATHUR</b>		22e. ADDRESS <b>17 Marshall Rd Waldorf Md 20694</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-18-1986</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Barstow</b>	COUNTY STATE <b>Calvert Md.</b>
24. FUNERAL DIRECTOR NAME <b>DONALD V. BORGWARDT</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1986</b>	25b. REGISTRAR'S SIGNATURE <b>W. J. Anderson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "OFFICE" are faintly visible.]*

00-19938

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AND ONE WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
Sharon			T.			Reamy			09-28-1986			8:30 AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		Cau.		July 24, 1937		49 YRS.		MONTHS DAYS		HOURS MIN.		Sept. 28, 1986		8:30 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.				U.S.A.								Prince George's MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Greenbelt				18-G Ridge Road				Clerk				Dept. Of Defense							
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Prince Geo.		Greenbelt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18-G Ridge Road 20770	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
William Earl Thomas						Ethel Marie Loehr													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
(YES, NO, OR UNKNOWN)						(IF YES, GIVE WAR OR DATES)						6317 Den Lee Dr.							
No						577-52-6263						Debra L. Winterwerp Clinton, Md. 20735							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Acute Myocardial Disease</u>																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																			
(b) _____																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10.																			
None																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
				M.D. Deputy				MEDICAL EXAMINER				9-28-86							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John S. Rogers, M.D.				1919 Seminary Road, Sil. Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				Oct/1/1986		George Washington Cem.				Adelphi P.G. Maryland									
24. FUNERAL DIRECTOR																			
FRANCIS GASCH'S SONS FUNERAL HOME, P.A.																			
4739 Baltimore Ave., Hyattsville, Maryland																			
25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE							
OCT 03 1986																			

OCT 03 1986

100% COTTON

MADE IN U.S.A.

100% COTTON



00-17399

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 / 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Laura W. Reigelman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 06 86</b>			2b. HOUR <b>4:50 P</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 31 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD.</b>			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hosptl</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Oxon Hill</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Williamson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Loveless</b>			16. STREET ADDRESS / ZIP CODE <b>317 Ferndale Pl. 20745</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-05-2443</b>		17. INFORMANT ADDRESS <b>Burton R. Reigelman 317 Ferndale Pl. Oxon Hill, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR <b>9/6 1986</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/6</b> 19 <b>86</b> , to <b>9/6</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>9/6</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>William J. Oetgen M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/7/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Oetgen, M.D.</b>						22e. ADDRESS <b>3611 Branch Ave. Temple Hills, Md. 20748</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>			23b. DATE <b>9/9/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home Oxon Hill, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1986</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



100-19249

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 9 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Geneva Wolfe Riddle			2a. DATE OF DEATH MONTH DAY YEAR September 19, 1986		2b. HOUR 12:10 P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD	
10. CITY OR TOWN OF DEATH Riverdale	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teller	12b. KIND OF BUSINESS OR INDUSTRY Banking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5291 85th Avenue 20784	
14. FATHER'S NAME FIRST MIDDLE LAST Ezra A. Wolfe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Tina High			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234-03-1781		17. INFORMANT 8614 Kiama Road, Laurel, Maryland David Riddle, 20708	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Arrhythmias</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1982</u> 19 <u>82</u> to <u>Sept</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 2nd</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Hema P. Yadla</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-20-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hema P. Yadla, M.D.		22e. ADDRESS 9470 Annapolis Rd., Suite 308, Lanham, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-23-86	23c. NAME OF CEMETERY OR CREMATORY Mt. Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Morgantown, Monongalia, W. Va.	
24. FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR SEP 25 1986	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 8 2 6 / 9 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLARD Earl ROYSTER			2a. DATE OF DEATH MONTH DAY YEAR 09 22 86			2b. HOUR 2:00 P.M.	
3 SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 12 24		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GEN. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't.	
						12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY PG 13c. CITY OR TOWN Landover							
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2360 Vermont Avenue 20785					
14. FATHER'S NAME FIRST MIDDLE LAST George Royster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Connley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Irene Royster (Wife) Same as 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastasis to Bone Lymp. Glad</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Pyelonephritis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 m</u> <u>2 m</u> <u>2 wks</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Obstructive Pulmonary Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-29-86</u> to <u>9-29-86</u> , that (I) (we) last saw the deceased alive on <u>9-29-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>CHANNES SAHAKIAN</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-23-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANNES SAHAKIAN				22e. ADDRESS 5632 Annapolis Rd Bladensburg Md 20710			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9/23/86		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Hines/Risoldi FH				ADDRESS 11800 New Hamp. AVE Silver Spring, MD		DATE REC'D BY REGISTRAR SEP 25 1986	
25. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE  
UNITED STATES  
DEPARTMENT OF  
THE ARMY  
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WASHINGTON, D. C.  
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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 7 9 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carmela NMI RUBINO</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 19, 1986</b>		2b. HOUR <b>1:25 A.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 14 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.			
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors' Hospital of Pr. Geo. Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Wash., D.C.</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1504 Taylor St. N.E. 20017</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Domenico Cuzzo</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carmela DeLascio</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-48-1562B</b>		17. INFORMANT <b>Michael Rubino</b>		ADDRESS <b>as in item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest rd to</b> <b>breathlessness</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>to</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 18</b> 19 <b>86</b> , to <b>Sept 19</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>Sept 18</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Benjamin S. Pecson</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-19-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Benjamin S. Pecson, M.D.</b>			22e. ADDRESS <b>6106 Old Silver Hill Rd., District Heights, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-22-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1986</b>				
25b. REGISTRAR'S SIGNATURE <b>John A. Deaton</b>									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 / 9 4			
1- STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <i>Lucille B. Ryan</i>				2a DATE OF DEATH MONTH DAY YEAR <i>8-29-1986</i>			
3 SEX <i>Female</i>				4 RACE <i>Cau.</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>9-27-1919</i>	
6 AGE (IN YEARS LAST BIRTHDAY) <i>66</i>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Georgia</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i>				10 CITY OR TOWN OF DEATH <i>Takoma Park</i>			
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary, Ret.</i>		12b KIND OF BUSINESS OR INDUSTRY <i>College</i>	
13a STATE <i>Maryland</i>				13b COUNTY <i>Prince George</i>		13c CITY OR TOWN <i>Takoma Park</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Needham J. Bowen</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Minnie Lee Wooten</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b SOCIAL SECURITY NO. <i>578-32-0073</i>		17 INFORMANT ADDRESS <i>Clifton C. Ryan 6800-10th Ave. Takoma Park, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Leukopenia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastatic Breast Cancer</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 days</i> <i>4 days</i> <i>3 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Respiratory Failure</i>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (1) (this hospital) attended the deceased from <i>29 Aug 86</i> to <i>29 Aug 86</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If (we) (we) did not, the body of the deceased was taken to the funeral home on <i>29 Aug 86</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above.)							
22b SIGNATURE <i>Thomas A. Bensimon MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>8/29/86</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas A. Bensimon</i>				22e ADDRESS <i>7525 Greenway Cir Dr. Greenbelt, Md</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>8-31-86</i>		23c NAME OF CEMETERY OR CREMATORY <i>Mt. Jackson Cemetery</i>		23d LOCATION CITY OR TOWN COUNTY <i>Mt. Jackson, Md. 20817</i>	
24 FUNERAL DIRECTOR NAME <i>Shen</i>				25a DECEASED'S RESIDENTIAL ADDRESS <i>Shen</i>			



0-17375

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 9 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE - G. SANFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-4-86</b>			2b. HOUR MIN. <b>5:48 P</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-21-27</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>59</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.			
10. CITY OR TOWN OF DEATH <b>BOWIE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bowie Health Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Meat Cutter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>16101 Ninecan Court 20772</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Sanford</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Virginia Cook</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 579-30-6188</b>		17. INFORMANT ADDRESS <b>Heidemarie A. Sanford same as 13e.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1985</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1985</b> to <b>until death</b> , that (I) (we) last saw the deceased alive on <b>7/9/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)									
22b. SIGNATURE <b>Venkat Mani</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/5/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VENKAT MANI M.D.</b>						22e. ADDRESS <b>8726 Woodyard Rd #503 CLINTON MD 20735</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>SEPT 8, 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cheltenham, Pr. George's, MD</b>		
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>			16000 Annapolis Road Bowie, MD 20715-3043			25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John A. Davidson-Randall</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

Handwritten notes and stamps, including "FBI" and "RECEIVED".

RECEIVED  
FBI  
JAN 10 1964  
COMMUNICATIONS SECTION

Handwritten notes include:  
- "FBI" (multiple instances)  
- "RECEIVED" (multiple instances)  
- "JAN 10 1964" (multiple instances)  
- "COMMUNICATIONS SECTION" (multiple instances)  
- "FBI" (multiple instances)  
- "RECEIVED" (multiple instances)  
- "JAN 10 1964" (multiple instances)  
- "COMMUNICATIONS SECTION" (multiple instances)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26796

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST Mary Ellen LAST Sansbury

2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR HOUR

9-11 1986

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH MONTH DAY YEAR

April 13, 1931

6. AGE (IN YEARS LAST BIRTHDAY)

55 YRS.

IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR

9-11 1986

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Prince George's

MD

10. CITY OR TOWN OF DEATH

District Hgts

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2600 Edfeldt Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Home

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

P. G.

13c. CITY OR TOWN

District Heights

13d. INSIDE CITY LIMITS? ☒ YES ☐ NO

13e. STREET ADDRESS

2600 Edfeldt Drive 20747

14. FATHER'S NAME FIRST MIDDLE LAST

Charles M. Doyle

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

Bernadette Kalstom

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

N/A

16b. SOCIAL SECURITY NO.

578-40-5290

17. INFORMANT

Percy B. Sansbury

ADDRESS

Same as 13 A-E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

Small cell carcinoma of the ovary

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Augusto P. Rodriguez

M.D.

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED

9-12-86

EXAMINER'S NAME (TYPE OR PRINT)

Augusto P. Rodriguez, M.D.

ADDRESS

5009 Rayburn Ct., Temple Hills, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Sept. 15, 1986

23c. NAME OF CEMETERY OR CREMATORY

Maryland Vet. Cem

23d. LOCATION CITY OR TOWN COUNTY STATE

Cheltenham Prince George's Md

24. FUNERAL DIRECTOR NAME

Lee Funeral Home, Inc.

25a. DATE REC'D BY REGISTRAR

SEP 16 1986

25b. REGISTRAR'S SIGNATURE

6683 Old Alexander Ferry Road Clinton, Md 20735

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

1-11-4  
1-11-4

May 1944

Final Report

Summary of the work done

Project No. 1000

1-11-4

1-11-4

1-11-4

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1-11-4

00-17866

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.		8 6 2 6 / 9 7					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GILBERT B SCHOTTA				2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 12 1986				2b. HOUR 1:30 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 29, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant/Manufacturing		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2510 Kittery Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Vincent Schotta				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Diffey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Doris Schotta Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of Bone = Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/86</u> to <u>9/12/86</u> , that (I) <u>did</u> lost saw the deceased alive on <u>9/11/86</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>do</u> (did) <u>not</u> believe the body after death.									
22b. SIGNATURE <u>Barry Rosenberg</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/12/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Rosenberg, M.D.				22e. ADDRESS 6501 Landover Road, Cheverly, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 09/13/86		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto., MD			
24. FUNERAL DIRECTOR NAME Cremation Society of MD				24b. ADDRESS 299 Frederick Rd. Balto., MD 21228		24c. DATE REC'D. BY REGISTRAR SEP 15 1986			
				24d. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

BP



1. *Exposition*  
 2. *Exposition*  
 3. *Exposition*  
 4. *Exposition*  
 5. *Exposition*  
 6. *Exposition*  
 7. *Exposition*  
 8. *Exposition*  
 9. *Exposition*  
 10. *Exposition*

1. *Exposition*  
 2. *Exposition*  
 3. *Exposition*  
 4. *Exposition*  
 5. *Exposition*  
 6. *Exposition*  
 7. *Exposition*  
 8. *Exposition*  
 9. *Exposition*  
 10. *Exposition*



0-19705

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD R. SCOTT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09-27-86</b>			2b. HOUR <b>5.18AM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 28 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE</b> MD.				
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>IceCream Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Artic Cream</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Seabrook</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>9981 Goodluck Road 20704</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 497-16-9185</b>		17. INFORMANT ADDRESS <b>Edward R. Scott Jr. 9981 Goodluck Rd Seabrook MD 20704</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>subacute bacterial pneumonia</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>emphysema, anemia, diabetes</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>9/26</b> to <b>9/27</b> 19 <b>86</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)					
22b. SIGNATURE <b>Lewis H. Dennis MD</b>		DEGREE		22c. DATE SIGNED <b>9/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEWIS H. DENNIS, M.D.</b>		22e. ADDRESS <b>831 UNIV BLVD. E. SILVER SPRING, MD. 20903</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9/29/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balt-Wash Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel PG MD</b>	
24. FUNERAL DIRECTOR <b>Fleck Funeral Home Inc.</b> ADDRESS <b>7601 Sandy Spring Road Laurel MD 20707</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

OCT 02 1986



00-18692

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

999999  
DHMH - 16-000 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 7 9 9

1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Janet M. SELAK				2a. DATE OF DEATH MONTH DAY YEAR September 12, 1986				2b. HOUR 5:25p.m.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince-Georges MD.							
11. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sacred Heart Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretarial-Clerical		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE District of Columbia				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2424 Pennsylvania Avenue 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Wentzel A. Selak				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Leonard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-60-0600		17. INFORMANT ADDRESS Alfred S. Fried 1725 K St. NW Wash., DC									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO, OR AS A CONSEQUENCE OF (b)  DUE TO, OR AS A CONSEQUENCE OF (c)  Arteriosclerotic Heart disease 5 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ① Dementia ② Degenerative arthritis of the spine ③ Diverticulosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/12/1985, to 9/12/1985, that (I) (we) lost saw the deceased alive on 7/4/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE J. M. Khatri				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/12/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IBRAHIM M. KHATRI				22e. ADDRESS 6525 Belcrest Rd Hyattsville MD 20782									
23a. BURIAL, CREMATION, REMOVAL SPEC. Burial		23b. DATE 9/17/86		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, MD							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D BY REGISTRAR SEP 19 1986		25b. REGISTRAR'S SIGNATURE John Davidson							



I . . .

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-18742

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 0 0

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		09 13 86		06 36A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		MONTH DAY YEAR		65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MASS.		U.S.A.		MARCH 31, 1921		PRINCE GEORGE'S MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PRINCE GEORGES		PRINCE GEORGE GEN HOSPITAL		RET. - PLUMBER		PLUMBING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		P.G.C.		NEW CARROLLTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		6127 LAMONT DR. 20784			
ALBERT J. SENIOR SR.		ALMA FLANNAGAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
YES		WWII		577-16-8143		GERTRUDE H. SENIOR 3106 WINDOM RD, MT. RAINIER Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF	
				Cardio Respiratory Arrest		(b) Acute Myocardial Infarction	
						(c) Severe Emphysema	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				Respiratory Failure			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-9-86 to 9-12-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		Suresh C. Gupta M.D.				9/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Suresh C. Gupta M.D.		3503 Perry St. MT. Rainier Md 20822		BURIAL		9-18-1986	
24. FUNERAL DIRECTOR		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
W. W. CHAMBERS CO.		MARYLAND VET. CEMETERY		CHELTENHAM, P.G.C.		Md.	
25a. DATE OF REGISTRATION		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE			
SEP 22 1986							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. 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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PAUL		G		SHELBY				9 27 86		8.30	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Male		White		March 11 1919		67		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Arkansas		USA				PRINCE GEORGES COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)									
CLINTON MD		SOUTHERN MARYLAND HOSPITAL									
12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY									
Security Guard		Pvt Ind.									
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Pr Geo		Temple Hill				5406 Winston Street 20748			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Roy Van Shelby						Grace Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				WWII		Marion V Shelby Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Stroke</u>										15 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carotid stenosis</u>										10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mell. hrs</u>										?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Brain tumor, urinary tract infection</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 12</u> , 19 <u>86</u> , to <u>Sept 27</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>Sept 27</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>[Signature]</u>				M.D.				9/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<u>Ronald L. Landman M.D.</u>				<u>7440 Pennsy/using Ave. Upper Marlboro, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				10 Oct 1986		Washington National				Suitland Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS											
Robert E. Wilhelm Funeral Home Suitland Maryland											
25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE			
OCT 06 1986								<u>[Signature]</u>			

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 26802

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA WALLACE SHIFFLETT			2a. DATE OF DEATH MONTH DAY YEAR September 21, 1986		2b. HOUR 9:31a <sub>M</sub>	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1914		
6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spotsylvania, VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Packer		
11. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AMI Doctors' Hosp. of Pr. Geo. Co.		12b. KIND OF BUSINESS OR INDUSTRY Ice Cream		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Greenbelt		
14 FATHER'S NAME FIRST LAST John Legal Guardian Waller		15 MOTHER'S MAIDEN NAME FIRST LAST Mattie E. Waller		13d. STREET ADDRESS / ZIP CODE 7819 Mandan Road 20770		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17 INFORMANT ADDRESS 6921 Groveton Drive Clinton, Md 20735		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY DUE TO, OR AS A CONSEQUENCE OF (b) 2ND STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARRHYTHMIA						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RESPIRATORY INFECTION						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/18/86 to 9/21/86, that (I) (we) last saw the deceased alive on 9/20/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE ASCO		DEGREE		22c. DATE SIGNED 9.21.86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARROH S. RAO		22e. ADDRESS 9131 Piscataway Rd #300 Clinton, Md 20735				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09/24/86		23c. NAME OF CEMETERY OR CREMATORY Washington Natl. Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince George's Md.		24 FUNERAL DIRECTOR Lee Funeral Home, Inc. NAME ADDRESS 13 Old Alexander Ferry Rd. Clinton, Md 20735				
25a. DATE REC'D. BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 refers to any injury, or other traumatic event, the medical examiner must be notified and a report filed.

State of Indiana

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JAN 10 1886  
OFFICE OF THE  
SHERIFF  
JAN 10 1886

00-18827

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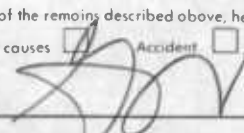
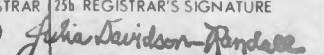
STATE OF MARYLAND

1- FOR 10/3/86 kam  
STATE REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF

86

26803

Rev.

1. DECEASED NAME (TYPE OR PRINT) <b>Marvin Simmons</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8/ 11/ 86</b>		2b. HOUR <b>9:01</b>
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 20 55</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>30</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>		10. CITY OR TOWN OF DEATH <b>Cheverly</b>			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>race track</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>082-48-2503</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Alcoholism and Drug Abuse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2 P.M. 8/11/1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject used alcohol and drugs</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>behind store located at 5908 St. Pleasant Dr.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Seat Pleasant, P.G. County Md.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>8/12/86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>		ADDRESS <b>111 Penn St.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>9-9-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1986</b>	
				25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE EACH OF ITEMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE OTHER VITAL RECORDS. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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RECEIVED 21 FEB 1965

UNCLASSIFIED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove the certificate from the deceased's file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the certificate must be examined and the medical examiner notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Aloysius A Size</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 5, 1986</b>			2b. HOUR <b>2:34A</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 11, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scranton, Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr George General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Butcher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A &amp; P Stores</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>DC</b>		13d. STREET ADDRESS / ZIP CODE <b>1383 North Carolina Ave NE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Joseph Size</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hannah Cusack</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWI 577-05-1951</b>		17. INFORMANT <b>Clarence Size</b>		ADDRESS <b>5601 Gallatin St Hyattsville MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rupture of Left Hip - Osteomyelitis - Death</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>August 18, 1986</b> to <b>September 5, 1986</b> that (I) (we) lost the deceased on <b>August 17, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Robert J. Gereige, M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. ADDRESS <b>4410 74th Avenue Landover Hills, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6 Sept 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>			
24. FUNERAL HOME NAME <b>Robert E Wilhelm Funeral Home</b>				ADDRESS <b>Suitland Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1986</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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08-18687

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LILLIAN M. SKELLY		2a. DATE OF DEATH MONTH DAY YEAR 9-15-86		2b. HOUR 6 P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4-9-90	6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WILMINGTON, Del.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.	
13a. STATE ---	13b. COUNTY ---	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4201 Massachusetts Ave, NW 20016
14. FATHER'S NAME FIRST MIDDLE LAST John T. Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine --- Zell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I 578-50-1612		17. INFORMANT 4000 Cathedral Ave, NW Eleanor J. Vaughan, Washington, D.C. 20016
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency 912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Aspiration of Blood & Stomach Contents (c) DUE TO, OR AS A CONSEQUENCE OF Gastrointestinal Bleed Gastrointestinal Bleed				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Abdominal Mass, Chronic UTI				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) (this hospital) attended the deceased from 11/7 19 84 to 9/15 19 86, that (1) (we) lost saw the deceased alive on 9/11 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (did not) (did not) view the body after death.				
22a. SIGNATURE Stuart J. Turkewitz, M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/15/86
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart J. Turkewitz, M.D.		22e. ADDRESS 7500 Greenway Center Drive Greenbelt, Md. 20770		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 9/16/86	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016		25a. DATE RECD. BY REGISTRAR SEP 19 1986		
		25b. REGISTRAR'S SIGNATURE		



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NAME	DATE	TIME	LOCATION	REMARKS
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...
John	7-1-1915	10:00	Washington, D.C.	...

Handwritten notes and stamps at the bottom of the page, including a circular stamp on the left and a rectangular stamp on the right.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Hugh Lanier Skinner, Jr.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR HOUR 9/29 19 80		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 21. 1928 57 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.	
12. CITY OR TOWN OF DEATH Upper Marlboro		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11801 Fairgreen Lane		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Vice President of Pepsi Co.	
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. CITY P.G. 13c. CITY OR TOWN Upper Marlboro		16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS 11801 Fairgreen Lane 20772	
18. FATHER'S NAME FIRST MIDDLE LAST Hugh Lanier Skinner, Sr.			19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lavinia Clements		
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes-Army (IF YES, GIVE WAR OR DATES) Korea		21. SOCIAL SECURITY NO. 579-34-2200		22. INFORMANT (Wife) ADDRESS Mrs. Blanche Skinner Address Same as No# 13.	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED?			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE	
33. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
34. ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>		35. (SPECIFY) <u>Deputy</u>		36. MEDICAL EXAMINER DATE SIGNED 9/30/86	
37. EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		38. ADDRESS 5009 Rayburn Ct. Camp Spgs, Md.			
39. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		40. DATE 10/02/86		41. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem.	
42. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland		43. DATE REC'D. BY REGISTRAR OCT 06 1986			
44. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.		45. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodriguez</u>			

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 0 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alfred (NMI) SLANE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 30, 1986</b>		2b. HOUR <b>9:57 p.m.</b>		
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 21, 1907</b>		6 AGE (IN YEARS (LAST BIRTHDAY)) <b>79</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD.	
10 CITY OR TOWN OF DEATH <b>LANHAM</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DOCTORS' HOSPITAL OF PR. GEO. CO.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electroplater</b>		12b KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Bowie</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Slane</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Perkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>101-03-2925</b>		17 INFORMANT ADDRESS <b>Rosemarie M. Browdy Bowie, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute lro Sepsis and Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Status Post cerebral infarction</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> 19 <b>86</b> to <b>9/30</b> 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. Dakheel M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10-1-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Riad Dakheel M.D.</b>				22e. ADDRESS <b>14300 Gallant Fox Ln., Bowie, Md. 20715</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct 3 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Beall Funeral Home</b>				ADDRESS <b>16000 Annapolis Rd. Bowie, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 02 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Juha Davidson-Henderson</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 0 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edward James Snyder</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-14-86</b>			2b. HOUR <b>7:55 P M</b>				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 2 1913</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67-72 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>72 0 0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.				
10 CITY OR TOWN OF DEATH <b>Aguasco</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>22410 Aguasco Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Aguasco</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John Edward Snyder</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Margaret Fisher</b>			13e. STREET ADDRESS / ZIP CODE <b>22410 Aguasco Rd. 20608</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1943-46 161 144418</b>		17 INFORMANT ADDRESS <b>Audrey J. Snyder - same</b>					
18. CAUSE OF DEATH Enter only one cause pertaining to (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic Bladder Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Partial Bowel Obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9 11 19 86</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>LAPLAGE / WALDORF, MD 20607</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>1981</b> , 19 <b>9/14</b> , 19 <b>86</b> , that (we) last saw the deceased alive on <b>9/11</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>George D. WATKIN</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/14/86</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>					23b. DATE <b>9-15-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>					ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia...</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 26807

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
  
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Paul		MIDDLE David		LAST Southern		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH SEP		DAY 13		YEAR 1988		TIME P	
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		9. DATE PRONOUNCED DEAD		MONTH SEP		DAY 13		YEAR 1988	
Male		White		Feb. 18, 1922		64						P		M		P		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County							
North Carolina				U.S.A.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Hyattsville				5606 31st Avenue				Night Watchman				Mrs. K's							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				P.G.				Hyattsville				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5606 31st Avenue 20782			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT (Sister)			
George				Southern				Annie				Bodenheimer				5606 31st Avenue			
No				578-12-4578				Alpha S. Murray				Hyattsville, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
None																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								DATE SIGNED							
John S. Rogers, M.D.				1919 Seminary Rd. Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				09/17/86				Cedar Hill Cemetery				Suitland P.G. Maryland							
24. FUNERAL DIRECTOR Francis Casch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
SEP 18 1988																			

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FOOT COTTON

MAINTAINED

1/10/11



00-15572

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARIE SPATES</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>86</b>			2b. HOUR <b>5<sup>PM</sup></b>					
3. SEX <b>F</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>20</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7c. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.					
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenbelt Nurs. Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sec'y Service</b>			
13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Cheverly</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6409 Landover Rd. 20785</b>		
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>K.</b> LAST <b>Wallace</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b> MIDDLE <b>C.</b> LAST <b>C.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>011-10-4939</b>		17. INFORMANT <b>3505</b> ADDRESS <b>Hamilton St. Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>sepsis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>COPD, Multiple Jacobian Ulcers, Cerebral and Cerebellar Atrophy</b>											
19a. DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>N/A</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (1) (this hospital) attended the deceased from <b>7/5</b> 19 <b>86</b> to <b>8/10</b> 19 <b>86</b> , that (1) <input checked="" type="checkbox"/> saw the deceased alive on <b>8/10</b> 19 <b>86</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)											
22a. SIGNATURE <b>Don H. Yablonski</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Don H. Yablonski</b>						22e. ADDRESS <b>10300 Greenbelt Rd, Seatons, Md 20706</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>8-10-86</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1986</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified by a physician.

BP



00-18739

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 26811

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Caroline V. Stabler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 15, 1986</b>		2b. HOUR <b>2:16p.</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 6, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home, Inc.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Prince-Georges</b>		13c. CITY OR TOWN <b>College Pk</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fletcher P. Veitch, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Laura Boyle</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO <b>220-34-7932</b>	
17. INFORMANT (Brother) <b>Fletcher P. Veitch, Jr.</b>		ADDRESS <b>Box 513 Lexington Park</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident 2 days</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized atherosclerosis</b>		APPROXIMATE DATE OF DEATH <b>Maryland 20659</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-21</b> , 19 <b>80</b> , to <b>8-27</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>8-27</b> , 19 <b>86</b> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> (did) <del>did not</del> view the body after death.							
22b. SIGNATURE <b>Don B. Cameron</b>		22c. DATE SIGNED <b>9-15-86</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DON B. CAMERON</b>			
22e. ADDRESS <b>6005 LANDOVER RD CHEVERLY, MD 20785</b>		22f. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>09/17/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Springs Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sandy Springs Maryland</b>	
24. FUNERAL DIRECTOR'S NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b>		24b. ADDRESS <b>4739 Baltimore Avenue Hyattsville, Maryland 20781</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1986</b>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

BP

00-16738

Station

State

County

X

Section

Page

0-17359

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 2 6 8 1 2

1. DECEASED NAME (TYPE OR PRINT) Helen E. Steed			2a. DATE OF DEATH MONTH DAY YEAR September 5, 1986			2b. HOUR M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 29, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.				
10. CITY OR TOWN OF DEATH Fort WASHINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3101 Steed Road Ft. Washington Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3101 Steed Road 20744	
14. FATHER'S NAME FIRST MIDDLE LAST Low Edelen Steed			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Delia M. Gannon			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. N/A			17. INFORMANT John E. Watson, Jr.			221 Arundel Rd Riviera Beach Md 21122				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Dissecting Aortic Aneurysm</u> Approximate Interval Between Onset and Death: <u>3 wks</u> <u>10 yrs</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>80</u> to <u>9-5</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-4</u> 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If yes, (did) (did not) view the body after death.)										
22b. SIGNATURE <u>Thomas F. Cleary</u> DEGREE						22c. DATE SIGNED Sept 6, 1986		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. Cleary, MD		
22e. ADDRESS 9131 Piscataway Rd. Clinton, Maryland						23a. BURIAL, CREMATION, REMOVAL Burial				
23b. DATE 09/08/86			23c. NAME OF CEMETERY OR CREMATORY Steed Family Cemetery			23d. LOCATION (CITY OR TOWN COUNTY STATE) Clinton Prince Georges Md				
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc. 16633 Old Alexander Ferry Rd Clinton Md 20735						25a. DATE REC'D. BY REGISTRAR SEP 8 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0-17328

MADE IN U.S.A.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 1 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Jessie K Stehr</i>			2a. DATE OF DEATH MONTH DAY YEAR September 18 1986			2b. HOUR A 2:35 M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH March 27 1912		6 AGE (IN YEARS LAST BIRTHDAY) 74		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.			
10 CITY OR TOWN OF DEATH Bowie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12608 Chanler Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Dept Navy	
13a. STATE Maryland		13b. COUNTY Pr Geo		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12608 Chanler Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Keir				15. MOTHER'S MAIDEN NAME MIDDLE Jessie Sutherland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 38 4054		17. INFORMANT ADDRESS Md Henry Stehr 3912 Croydon Lane Bowie					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>colonic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, BARR, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 10</u> , 19 <u>86</u> , to <u>9/18</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>9/14</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stuart E. Selouch, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selouch, M.D.				22e. ADDRESS 51 Franklin St. Annapolis Md.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 22 Sept 86		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION SUITLAND		23e. COUNTY Maryland	
24. FUNERAL DIRECTOR'S NAME Robert E Wilhelm SUITLAND Maryland				25a. DATE REC'D. BY REGISTRAR SEP 24 1986		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place word "buried" in box, and return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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18022



00-17744

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 8 1 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Annie Ward Virginia Stevens</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-7-86</b>			2b. HOUR M <b>AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-3-07</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>79</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>A.A. Co. MA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Forestville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Regency Health Service INC</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Beautician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beaut. Shop</b>	
13a. STATE <b>Fla.</b>		13b. COUNTY <b>Broward</b>		13c. CITY OR TOWN <b>Ft. Lauderdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5251 South West 34th St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Henry Ward</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Hall</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-03-4559</b>		17. INFORMANT <b>Etha Thompson</b>		ADDRESS <b>Woodbridge Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>12 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus; Peripheral vascular insufficiency</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/26 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8/26 1986 to 9/7 1986</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/26 1986</b> to <b>9/7 1986</b> , that (I) (we) last saw the deceased alive on <b>8/26 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. Sanford Young</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/7/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-9-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Belt Balt Md</b>			
24. FUNERAL DIRECTOR NAME <b>Hardesty Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 11 1986</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

44551-00

100% COTTON FIBER  
MADE IN U.S.A.

86-18340

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>MATILDA G Stevenson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>9-13-86</b> 2b. HOUR <b>5:24 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 4, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>81 YRS.</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges MD.</b>			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So. md. Hospital Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>14003 Old Marlboro Pike 20772</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John ---- Richmond</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cecelia --- Sayer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>155-30-3147</b>		17. INFORMANT ADDRESS <b>Hospital Records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-15, 1986</b> to <b>9-13, 1986</b> , that (I) (we) last saw the deceased alive on <b>9-12, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Samtani</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>9-13-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. SAMTANI</b>					22e. ADDRESS <b>7501 Surratts Rd., Clinton, Md. 20735</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/15/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restland Memorial Park Hanover (Morris County) N.J.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR <b>Richard A. Coleman - Upper Marlboro, Md. 20772</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1986</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

978635

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

0-18310

COLON ABEL

00-1778

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26816

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Louis Stewart								9-9-86								3:35			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY			
Male		Black		7-1-1919		67 YRS.						9-9-86							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Alabama				U.S.A.								Capitol Heights, Md.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Capitol Heights				400 Cedarleaf Ave								Retired Air Force				Air Force			
13a. INSIDE CITY LIMITS?				13b. STREET ADDRESS				13c. STREET ADDRESS				13d. CITY OR TOWN				13e. STATE			
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				400-Cedarleaf Ave				400-Cedarleaf Ave				Capitol Heights				Maryland			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, OR COAST GUARD (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
John Stewart				Annie V. Harris				Yes				W.W. II 410-07-1567				Mrs. Verlyle Stewart-Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
PART I DEATH WAS CAUSED BY:												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)				DUE TO, OR AS A CONSEQUENCE OF											
								(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				Ethylin															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY			
22a. I certify that I took charge of the remains described above, held on death resulted from:				Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED							
Augusto P. Rodriguez				Deputy								9-9-86							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Augusto P. Rodriguez, M.D.				5009 Rayburn Ct, Temple Hills, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATOR				23d. LOCATION				23e. COUNTY			
Burial				9-15-86				Arlington Nat. Cemetery				Arlington				Virginia			
24. FUNERAL DIRECTOR NAME				25. REGISTRATION NO.				26. REGISTRATION EXPIRATION DATE				27. REGISTRAR'S SIGNATURE							
Samuel R. Woodford				1722-North Capitol St. N.W.				DCEP 11 1986				Julia Davidson-Rodriguez							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

RECEIVED OCT 10 1964

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION



00-20399

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 1 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <b>VERNELL</b> MIDDLE <b>VERNELL</b> LAST <b>STOKES</b> <b>VERNELL STOKES</b>		2a. DATE OF DEATH MONTH <b>9</b> DAY <b>28</b> YEAR <b>86</b>		2b. HOUR <b>1000 P</b> M
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>OCTOBER</b> DAY <b>9</b> YEAR <b>1932</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO MD.</b>
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SO-MARY LAND HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Presser</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>private</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Suitland</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>EUGENE</b> MIDDLE <b>DURHAM</b> LAST <b>DURHAM</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARGIANNA</b> MIDDLE <b>ALSTON</b> LAST <b>ALSTON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Daughter</b> ADDRESS <b>Delores Clemons-4902 Keir Ct Suitland, Md.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Colon cancer with abdominal carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 5 mos.</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-5</b> 19 <b>86</b> , to <b>9-28</b> 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>9-27</b> 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Kai-Yen Y. Gung, MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9-29-86</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kai-Yen Y. GUNG, MD</b>		22e. ADDRESS <b>8926 Woodland Rd #201 Clarks, MD 20735</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10/3/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Maryland</b>
24. FUNERAL DIRECTOR NAME <b>ALEXANDER S. POPE-2617 Pa Ave SE Wash., D.C.</b>		25a. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <b>OCT 9 1986</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP

DHMH : 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201







00-19722

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMITS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

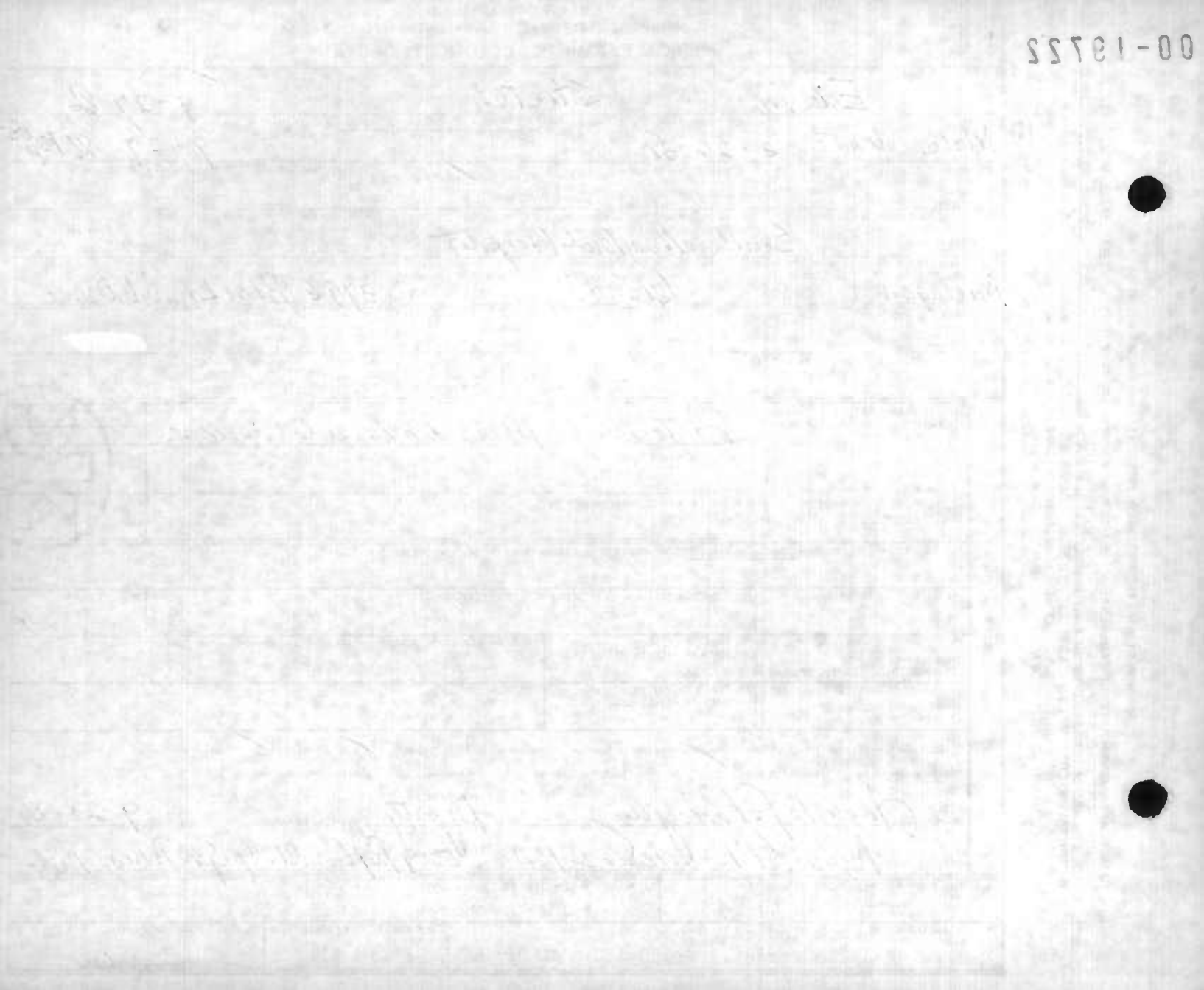
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Edwin G. Stretch		9-27-86		8:15 PM	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	White	6-26-38	48 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Indiana		United States		Prince George's MD.	
9 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Clinton		Southern Maryland Hospital		Engineer	
13a STATE		13b COUNTY		13c. STREET ADDRESS	
Michigan		Kent		3796 Blackhawk Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Glen Stretch		Edna West			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		378-38-4747		Deanne W. Stretch, Same as 12	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Augusto P. Rodriguez		M.D. Deputy		9-28-86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Augusto P. Rodriguez		5009 Parkhurst Ct. Gp Spr Bldg. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		10-1-86		Grandville Cemetery	
				Grandville, Michigan	
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Cook Funeral Home		00702 1986		[Signature]	
4235 W. Prairie Street, Grandville, MI 49418					

998999  
07/86  
75M  
DHMH-17  
(VR A15 ME (5))



00-19218

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR
Ruth KIRBY			Stout			9 19 86					12 <sup>03</sup> PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		11 12 97		88 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina		USA				Prince Georges MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Adelphi		Presidential Woods Nursing Home						Assembler-Vitro Corp			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		907 DEVERE DR. 20903			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
ELISHA KIRBY			ROSA SHOPE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			None			907 Devere Drive					
			196-20-9284A			Margaret P. Greenberg, Friend S.S. Md. 20903					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Auto Cardiorespiratory Arrest										9/19/86	
DUE TO, OR AS A CONSEQUENCE OF (b) Auto Aspiration Pneumonia										9/86	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD										#982	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe Dementia, Deaf-Mute, CVA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
No			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE					
						6/18/79 4/19/86					
22a. I certify that (1) this hospital attended the deceased from 6/18/79, 19, to 4/19/86, 19, that (2) I last saw the deceased alive on 9/10/86, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
DB Patruh MD									9/19/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
GB Patruh MD			9221 Lakesville Rd Silver Spring, Md 20903								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		9-22-1986		Monongahela Cemetery		Bradock Allegheny Co. PA.					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W.W. Chambers Co. 5801 Cleveland Ave Riverdale Md 20715			SEP 26 1986			[Signature]					



12  
10-168741- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 6 8 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W Summerville			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30 1986		2b. HOUR 11:42am
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec 10, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.	
10. CITY OR TOWN OF DEATH Andrews AFB	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Military	12b. KIND OF BUSINESS OR INDUSTRY USN	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Florida			13b. COUNTY Orange	13c. CITY OR TOWN Orlando	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Summerville		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willena Mae Stanley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1937-1959 482-05-4446		17. INFORMANT ADDRESS Bessie Mildred Summerville Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>ELECTRO MECHANICAL DISSOCIATION</u> DUE TO OR AS A CONSEQUENCE OF: <u>respiratory failure and acidosis</u> DUE TO: <u>esophageal cancer</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 min 48 hours 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a					
19a. DATE OF OPERATION 25 Aug 86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ESophageal cancer		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>25 Aug</u> 19 <u>86</u> , to <u>30 Aug</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>30 Aug</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE [Signature]		DEGREE		23c. DATE SIGNED 30 Aug 86	
23b. PHYSICIAN'S NAME (PRINT) QUIGLEY, Terence M.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		23d. ADDRESS Box 3476 MCMC Andrews AFB, MD Box 3476 MCMC Andrews AFB, DC	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4 Sept 86	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md	
24. FUNERAL DIRECTOR'S NAME Robert E Wilhelm		ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR SEP 3 1986	25b. REGISTRAR'S SIGNATURE [Signature]





00-18315

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM A. SWENTON			2a. DATE OF DEATH MONTH DAY YEAR 9 12 '86		2b. HOUR 8:09PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR OCT 30, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH CLinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF YEARING (LAST)) Aircraft Elec tronic repair		12b. KIND OF BUSINESS OR INDUSTRY US Gov't
13a. STATE Maryland			13b. COUNTY Pr Geo	13c. CITY OR TOWN Morningside	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Swenton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hedwig Augustyn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 196-01-5735	17. INFORMANT June E Swenton Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE, SEVERE DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBROVASCULAR DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I), (this hospital) attended the deceased from 9/19, 1986, to 9/12, 1986, that (I) (we) lost saw the deceased alive on 9/12, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. A. V. C. M.		DEGREE		22c. DATE SIGNED 9/13/86.	
22d. PHYSICIAN'S NAME (TYPE CURRENT) GURBOX Nachman		22e. ADDRESS 8926 Woodyard Rd, Clinton, Md. 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-16-86	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md
24. FUNERAL DIRECTOR NAME Robert E Wilhelm		ADDRESS Funeral Home Suitland, Md.		25a. DATE REC'D. BY REGISTRAR SEP 17 1986	25b. REGISTRAR'S SIGNATURE J. S. Anderson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

BP

DHMH - 16 60M 7/84

(VRA 15, 4)





00-19252

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26822																																							
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										2b. HOUR																																							
Victoria L. TATE																				9 20 19 86																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										7c. DATE PRONOUNCED DEAD										7d. HOUR									
Female										Caucasian										7-31-68										18 YRS.										MONTHS DAYS HOURS MIN										9 20 19 86										11:20 PM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH																																							
Illinois										U.S.A.																				Prince George's County MD.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																							
Upper Marlboro										5300 blk. Mellwood Rd.										Student										School																																							
13a. STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS?										13d. STREET ADDRESS																																							
Maryland										Prince George's										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										1406 Karen Blvd. 20743																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																											
Robert D. Tate										Rosita M. Moses																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																							
No										578-82-1652										Robert D. Tate										Same as 13																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART I DEATH WAS CAUSED BY:										Multiple injuries																																																											
8151 IMMEDIATE CAUSE (a)																																																																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										(b)																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																											
										(c)																																																											
										DUE TO, OR AS A CONSEQUENCE OF																																																											
										(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																	
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																	
										10:10 AM 9-20-1986										Passenger of auto/fixed object impact.																																																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																	
										road										5300 blk. Mellwood Rd., Upper Marlboro, MD																																																	
22a. I certify that I took charge of the remains described above, held on death resulted from:										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										Prince George's																																																	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																																					
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																	
<i>Dennis F. Smyth</i>										M.D. Assistant										MEDICAL EXAMINER										9-21-86																																							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																											
Dennis F. Smyth, M.D.										111 Penn St., Balto., MD 21201																																																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																							
Burial										9-24-86										Ft. Lincoln Cemetery										Brentwood, Prince George's Md.																																							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Francis Gasch's Sons Funeral Home, P.A.										SEP 25 1986										<i>Francis Gasch</i>																																																	
4739 Baltimore Avenue Hyattsville, Md. 20781																																																																					

07/84  
25M

BP  
DHMH - 17  
(VR AIS ME (5))

00-10325



VOID

CERTIFICATE # 86-26823



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0-10165

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR 1. STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 2 6 8 2 4	
1. DECEASED NAME (TYPE OR PRINT) <b>Dora Thomas</b>				7a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>Sept. 20, 1986 8:45 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 1 1888</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>98</b>		8. AGED <input checked="" type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>	
10. CITY OR TOWN OF DEATH <b>Adelphi</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presidential Woods</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>	
13a. STREET ADDRESS / ZIP CODE <b>1801 Metzert Rd. 20783</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <b>1801 Metzert Rd. 20783</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James T. Morrison</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Janie Brown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO <b>267-48-9265</b>		17. INFORMANT ADDRESS <b>Doretta Gianetti 10902 Boredale Dr. 20783</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b>	
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CAD, Renal Insufficiency, COPD</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)	
22a. I certify that I am a physician, attended the deceased from <b>7/8/81</b> to <b>9/20/86</b> and that in my opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE <b>Dr. B. Patrick III MD</b>		22c. DATE SIGNED <b>9/20/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. B. Patrick III MD</b>		22e. ADDRESS <b>9221 Cokesville Rd Silver Spring, MD 20910</b>		22f. REGISTERAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/23/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery of Manchester</b>	
23d. LOCATION <b>Merriwether Georgia</b>		23e. NAME OF CEMETERY OR CREMATORY <b>City Cemetery of Manchester</b>		23f. LOCATION <b>Merriwether Georgia</b>	
24. FUNERAL DIRECTOR <b>Donald V. Borgwardt</b>		24b. ADDRESS <b>4400 Powder Mill Rd. Beltsville Md 20705</b>		25a. DEPUTY REGISTRAR <b>SEP 25 1986</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		25d. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

00101-00

31 OCT 1964

10101-00

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00-19933

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jennie Thomas			2a. DATE OF DEATH MONTH DAY YEAR 09/28/86			2b. HOUR 3:20PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 03 1884		6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Ft. Washington		13d. INSIDE CITY LIMITS? <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 8302 Bernard Drive 20744									
14. FATHER'S NAME FIRST MIDDLE LAST William Carpenter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 296-24-5454		17. INFORMANT Josephine Thomas Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>urinary tract infection</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>ASCD</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> 19 <u>86</u> , to <u>9/28</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/28/86</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> F. M. Ryan MD						22c. DATE SIGNED 9/28/86			
22d. ADDRESS 9401 Indus Health Hg. Ft. W. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Oct. 1, 1986		23c. NAME OF CEMETERY OR CREMATORY St. George Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE St. George island		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Md.						25a. DATE REC'D. BY REGISTRAR OCT 03 1986		25b. REGISTRAR'S SIGNATURE St. Mary's Md.	

MEDICAL CERTIFICATION

F

9/9

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



The area for inspection  
is indicated by the lines



Case



12-10-1944

Schubert  
Lithuania 1944-1945

12-10-1944



00-19578

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MABEL J. TIPPETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-25-86</b>		2b. HOUR <b>2:05pm</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 27 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov't.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Forestville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Johnson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Berry</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-18-0416A</b>	17. INFORMANT ADDRESS <b>Emily A. Shipp 3737 Donnell Dr. 204 Forestville, Md. 20747</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumonia &amp; pleural effusion</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Urinary tract Infection</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/25/86</b> to <b>9/25/86</b> , that (we) last saw the deceased alive on <b>9/25/86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Boris G. Kalukin, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/25/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BORIS G. KALUKIN, MD</b>		22e. ADDRESS <b>9131 PISCATAWAY RD CLINTON MD 20734</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-29-86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>G.P. Kalas F.H. 6160 Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Riddell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

57291-00

05-17698

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel Catherine Tonioli			2a. DATE OF DEATH MONTH DAY YEAR 08 25 86			2b. HOUR 5:45 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.			
10. CITY OR TOWN OF DEATH Adelphi		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presidential Woods Health Care Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Shady Side		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Steamboat Rd. 20867	
14. FATHER'S NAME FIRST MIDDLE LAST James Crampton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Pennyfield					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-22-7305		17. INFORMANT 3629 Dammys Lane Jo Anne Groves- Daughter Alex., Va. 22311					

18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) <u>Coronary heart</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) <u>Alzheimer's Disease</u> DUE TO, OR AS A CONSEQUENCE OF c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 Minutes</u> <u>6 years</u>	
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## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11 Aug 1986</u> to <u>25 Aug 1986</u> , that (I) (we) lost <u>11 Aug 1986</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE <u>Michael Bonczkowski</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>25 Aug 86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Bonczkowski</u>		22e. ADDRESS <u>1500 W. S. Braddoc Rd. Alexandria, Va. 22302</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-26-86		23c. NAME OF CEMETERY OR CREMATORY Everly Funeral Homes		23d. LOCATION CITY OR TOWN COUNTY STATE Alex., Va.	
24. FUNERAL DIRECTOR <u>Carl A. N...</u>				25a. DATE REC'D BY REGISTRAR <u>Aug 28 1986</u>		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 as any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

BP

20% CUMULATIVE

10/1/71

10/1/71

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR STATE REGISTRAR		3- MEDICAL EXAMINER'S CERTIFICATE OF DEATH				2- 2 6 8 2 8		REG. NO. 12					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI-MATED		MONTH DAY YEAR		2b. HOUR	
Albert Eugene Toomer								<input checked="" type="checkbox"/> 9/18		1986			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male		BLACK		Apr. 20, 1926		60 YRS.		MONTHS DAYS HOURS MIN.				9/23 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
South Carolina		USA				Prince George's County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
College Park		9314 Cherry Hill Road, #926		Security Officer		Gov't							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Prince George's		College Park				9314 Cherry Hill Road, #926					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WW II		126-16-3498		Earlise Edwards (cousin)		414 Christopher Ave. Gaithersburg, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Acute myocardial disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				DUE TO, OR AS A CONSEQUENCE OF									
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. 19		None									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE									
EXAMINER'S NAME (TYPE OR PRINT)		M.D. Deputy		MEDICAL EXAMINER		1919 Seminary Road		Silver Spring, Montgomery County, MD					
John S. Rogers, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Removal		9-23-86											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
State Anatomy Board		Baltimore, Md.		SEP 26 1986		Julia Tindan-Rudman							

20% COTTON LIBER

CHIEFMAN BOND



00-19934

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 2 9

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Francis P Tuell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 30 1986</b>			2b. HOUR P <b>1:55 M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 9 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE George MD.</b>			
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greenbelt Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. STREET ADDRESS / ZIP CODE <b>7501 Democracy Blvd B-215</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Tuell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>Peacetime 577-01-2942</b>		17. INFORMANT ADDRESS <b>Nancy A Tuell Same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SENILITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DECUBITUS ULCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/10 1986</b> to <b>9/30 1986</b> , that (I) (we) last saw the deceased alive on <b>2/15/1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Abdulhoseinn N. Adham</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-1-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDULHOSEINN N. ADHAM</b>						22e. ADDRESS <b>4467 OLD BRANCH AV. TEMPLE HILLS MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>10 Oct 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory Suitland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PG Md</b>		
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>						ADDRESS <b>Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 03 1986</b>	
						25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove the carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked as item 18, it shows any injury, or other trauma, or other cause of death.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





00-19665

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE R. TULL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/27/86</b>			2b. HOUR <b>9:30 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 20 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		9b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SOUTHERN MARYLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Calvert</b>		13c. CITY OR TOWN <b>No Beach</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>7016 Albany Avenue 20714</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Price Tull</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Kidder</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT <b>Donald R Tull</b>		ADDRESS <b>712 Shelby Dr Oxon Hill Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Lung Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Pneumonia - Seizure disorder</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUN 64</u> 19 <u>54</u> to <u>SEP 27</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>SEP 26</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. Sanford Young</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/27/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. SANFORD YOUNG</b>				22e. ADDRESS <b>11701 LIVINGSTON ROAD Ft. WASHINGTON</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>30 Sept 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Veterans</b>		23d. LOCATION <b>Cheltenham Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert E Wilhelm</b>				Firm <b>Suitland Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 01 1986</b>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Albert Hill Turner</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9/30 19 86</b>			2b. HOUR M <b>9:20 A. M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 24, 1894 92 YRS.</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>92</b>		7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN <b>9:20</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b>		
11. CITY OR TOWN OF DEATH <b>Mitchellville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3700 Enterprise Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Builder</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Mitchellville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>3700 Enterprise Road</b>			13f. CITY OR TOWN <b>20706</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>Stewart Turner</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lily Mae Forney</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-01-7425</b>			17. INFORMANT <b>Albert W. Turner (Son)</b>			18. ADDRESS <b>4009 Enterprise Rd. Mitchellville, Md. 20705</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>chronic myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>None</b>											
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>			M.D. <b>Deputy</b>			MEDICAL EXAMINER			DATE SIGNED <b>9/30/86</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>			ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery County, MD</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/02/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>			
4739 Baltimore Avenue Hyattsville, Md. 20781											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

001-3010-100

100-19844

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marcus W Volk</b>				2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>9-26 1986</b>				2b. HOUR M <b>231</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11/3/19 66</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Lanham</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctors Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marcus W. Volk</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mrs. Ruth Volk</b>				16. SOCIAL SECURITY NO. <b>220-10-9264</b>	
17. INFORMANT ADDRESS <b>5-G Ridge Road Greenbelt, Md.</b>				18. CAUSE OF DEATH (Enter only one cause and the far (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Throat cancer</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22b. ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>				22c. TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER	
22d. DATE SIGNED <b>9/27-86</b>				22e. ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>9-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 03 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17  
(VR A15 ME (5))

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00-17828

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>AKA Jacquelyn R. Wainwright</b> <b>1. Jacqueline R. Wainwright</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-9 1987</b>		2b. HOUR M <b>4:45</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1945</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>40 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b>
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Beautician</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Lanham</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>William Robinson</b>		15. MOTHER'S MAIDEN NAME <b>Ruby Sellers</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>191-38-0790</b>		17. INFORMANT <b>7947 Dellwood Avenue</b> <b>Darrell Wainwright, Lanham, Maryland</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked bilateral pulmonary edema</b> 8501 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Salicylate overdose</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Tremor + mitral leaflet vegetations</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>Augusta P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>9-10-86</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusta P. Rodriguez</b>		ADDRESS <b>P.G. Hospital, Cheverly, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/12/86</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover P.G. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>J.B. Jenkins Funeral Home, Landover, Md. 20785</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1986</b>		25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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Cert. amended by M.E. 10/11/86 dad  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 6 2 6 8 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie Ann Walton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 26, 1986</b>			2b. HOUR <b>7:20 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 18, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>AMI Doctors' Hosp. of Pr. Geo. Co.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Upper Marlboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>(Unknown)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(Unknown) (Unknown) (nee Star)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>13830 Willoughby Rd. Samuel A. Walton-Upper Marlboro, Md. 20772</b>				

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

**PULMONARY Edema**

## DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

## (b)

**Arteriosclerotic Heart disease**

## DUE TO, OR AS A CONSEQUENCE OF

## (c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**2 1/2 yrs****2 years**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

**COUMADIN EXCESS**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 20, 1986</b> to <b>Sept. 26, 1986</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 26, 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Roger Ingham</b>		22c. DEGREE <b>Natural Cert. approved by Dr. A. Dixon</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <b>9/27/86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roger Ingham, M.D.</b>				22e. ADDRESS <b>6510 Kenilworth Avenue, Riverdale, Md. 20737</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/30/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Richard A. Coleman</b> Funeral Home				Upper Marlboro, Md. 20772		25a. DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>	
				25b. REGISTRAR'S SIGNATURE <b>Richard A. Coleman</b>			

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(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered in the Bureau of Vital Records, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

00-10257

47

DOWN

FOR COTTON ALPAC

VOID

CERTIFICATE # 86-26835



00-18415

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NORA			FIRST MIDDLE LAST V. WATTS			2a. DATE OF DEATH MONTH DAY YEAR 9-6-86				2b. HOUR 7:50 P.M.							
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9 3 85		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P. G. County MD.											
10. CITY OR TOWN OF DEATH Huntersville, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Consolidated Center						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY NONE							
13a. STATE MD			13b. COUNTY P.G.		13c. CITY OR TOWN Hillcrest Hts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2019 Gaither St. 20748								
14. FATHER'S NAME FIRST MIDDLE LAST John Burley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Armalla (unknown)				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-66-8793		17. INFORMANT Evelyn W. West		ADDRESS 2019 Gaither St. Hillcrest Hts. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. CVA -												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5/17, 1983, to 9/6, 1986, that (I) (we) last saw the deceased alive on 8/28, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE K. M. ...								DEGREE		22c. DATE SIGNED 9-7-86.							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEZIA MUSTOIAN								22e. ADDRESS 2235 ... md 20748									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/11/86		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince George's MD							
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E.				25a. DATE REC'D. BY REGISTRAR SEP 18 1986				25b. REGISTRAR'S SIGNATURE									

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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00-17402

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Martha G. WENDORFF</b>			2a DATE OF DEATH MONTH DAY YEAR <b>September 4, 1986</b>		2b HOUR <b>6:30a.m</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>November 9, 1983</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>102</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince-Georges</b> MD.		
10 CITY OR TOWN OF DEATH <b>Hyattsville</b>	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sacred Heart Home, Inc.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE <b>Maryland</b>	13b COUNTY <b>Prince-Georges</b>	13c CITY OR TOWN <b>Hyattsville</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <b>6505 - 41st Avenue 20782</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Michael Kleinbouer</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine CapisZinski</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-44-5849</b>		17 INFORMANT ADDRESS <b>(Daughter) 6505 41st Avenue Florence W. Payne Hyattsville, Maryland 20782</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), (c), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Cerebral vascular accident</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) <del>this</del> hospital attended the deceased from <u>July 9, 1986</u> to <u>Sept 4, 1986</u> , that (I) <del>person</del> lost saw the deceased alive on <u>9/11</u> 19 <u>86</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>(did not)</del> view the body after death.					
22b SIGNATURE <u>Edward J. Pacious</u>		DEGREE <u>M.D.</u>		22c DATE SIGNED <u>9/4/86</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward J. Pacious, M.D.</b>		22e ADDRESS <b>1712 Eye St. NW Wash, D.C. 20006</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>09/08/86</b>		23c NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d LOCATION CITY OR TOWN <b>Brentwood</b>		COUNTY <b>P.G.</b>		STATE <b>Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>			25a DATE REC'D. BY REGISTRAR <b>SEP 9 1986</b>		
ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

BP

• 00000

22

448 *Journal of Management Inquiry* 15(4)



10-18962

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAGGIE M. WIGGINS			2a. DATE OF DEATH MONTH DAY YEAR 09-19-86			2b. HOUR 12:42 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY P. G.		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Bassett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Owens			16. SOCIAL SECURITY NO. 231-22-5366			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 231-22-5366			17. INFORMANT Paul Wi. Wiggins-2111 Va. Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Interstitial Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Klebsiella</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Coronary Artery Disease - Chronic Renal Insufficiency</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> 19 <u>86</u> to <u>9-19</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. Singh</u>			DEGREE MD MRCP			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SINGH			22e. ADDRESS 4700 Auth Place Suitland Md 20746						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-25-86		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P. G. Md.		
24. FUNERAL DIRECTOR NAME T. C. Pinckney			ADDRESS Spangler Funeral Home 524 - 8th St. N.E.			25a. DATE REC'D. BY REGISTRAR SEP 23 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. MONTH DAY YEAR			7b. HOUR		
BRUCE LEE WILLIAMS			8-31-86			19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			7d. HOUR		
Male	Black	03-02-48	38 YRS.			8-31-86			8:37A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Dist of Colum.			U. S. A.			Prince George's County			MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Capitol Hgts.			1 Cindy Lane Apt. 103			Brick Mason			Private		
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
D. C.			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1408 Newton St., NW.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
James Williams			J. D. Jones			Yes			3/68-3/70		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Washington, D.C.			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intravenous narcotism</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			? P.M. 8-?-86 19			subject used drugs					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE			8-31-86		
William M. Zane, M.D.			Assistant			SIGNED					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
William M. Zane, M.D.			111 Penn Street			Burial			06 Sept 86		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Lawrence W. Plunkett, Inc. Wash., D.C.			SEP 11 1986			Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))

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A-11

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00-18228

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. DATE OF DEATH				2c. DATE OF DEATH				2d. DATE OF DEATH			
Henry Nelson Williams				9/12/86				9/12/86				9/12/86				9/12/86			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH		11. BALTIMORE CITY OR COUNTY OF DEATH			
Male		White		Sep. 22, 1910		75 YRS.						Prince George's County		Prince George's County		Prince George's County			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				10. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.				U.S.A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Prince George's County				Prince George's County			
11. CITY OR TOWN OF DEATH				12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				14. KIND OF BUSINESS OR INDUSTRY				15. KIND OF BUSINESS OR INDUSTRY			
Hyattsville				In front of 5334 Baltimore Avenue				Cab Driver				Blue Bird Cab Company				Blue Bird Cab Company			
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				17. STATE				18. CITY OR TOWN				19. INSIDE CITY LIMITS?				20. STREET ADDRESS			
Maryland				P.G.				Mt. Rainier				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				4008 30th Street 20712			
21. FATHER'S NAME				22. MOTHER'S MAIDEN NAME				23. FATHER'S NAME				24. MOTHER'S MAIDEN NAME				25. FATHER'S NAME			
William S. Williams				Anna M. Nelson				William S. Williams				Anna M. Nelson				William S. Williams			
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				27. SOCIAL SECURITY NO.				28. INFORMANT				29. ADDRESS				30. ADDRESS			
No				225-28-4080				Ann L. Williams (Wife)				Mt. Rainier, Md.				Mt. Rainier, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) chronic myocardial disease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

None

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		P.M. 19		None	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion					
22b. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers, M.D.		Deputy		9/12/86	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Road Silver Spring, Montgomery County, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		09/15/86		Fort Lincoln Cemetery		Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.				SEP 18 1986		John S. Rogers, M.D.	
4739 Baltimore Avenue Hyattsville, Md. 20781							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "RM-3". RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP  
OHMH - 17  
(VR A15 ME (5))

0-11530

RECEIVED OCT 26 1962

U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST BERNARD		MIDDLE R.		LAST WILSON		2a. DATE OF DEATH MONTH 09		DAY 07		YEAR 86		7b. HOUR 7 05PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH Jan.		DAY 19,		YEAR 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66		7c. YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY								MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Retired									
13a. STATE d.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9203 Fowler Lane						20706	
14. FATHER'S NAME FIRST Alfred		MIDDLE		LAST Wilson		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST Allen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 168-12-9323		17. INFORMANT Louise M. Wilson		ADDRESS 9203 Fowler Lane								Lanham, Md. 20706	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral pulmonary aneurysm</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>		DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Malnutrition Thrombosis left leg</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> , 19 <u>86</u> , to <u>9/7</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>9/7</u> , 19 <u>86</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (this is not a legal statement).															
22b. SIGNATURE <u>Stephen P. Crossland, M.D.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/9/86</u>									
22d. PHYSICIAN'S NAME (PRINT) <u>Stephen P. Crossland, M.D.</u>		22e. ADDRESS <u>5711 SARVIS Ave. Suite 302</u> <u>Riverdale, Maryland</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN Washington, D.C.									
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Funeral Home		24a. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706		24b. DATE REC'D. BY REGISTRAR SEP 11 1986		24c. REGISTRAR'S SIGNATURE <u>Edmund Rendon</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

[illegible]

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

## MEDICAL CERTIFICATION

00-15570

200 COTTON





00-19378

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 4 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES BUCHANAN WILSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9. 25-86</b>			2b. HOUR <b>6:30<sup>M</sup></b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 20 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES CO</b> MD.		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. MARYLAND HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Iron Worker</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George</b>		13c. CITY OR TOWN <b>Accokeek</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William L. Wilson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anne Longest</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>220-09-9769</b>		17. INFORMANT ADDRESS <b>Eugene P. Wilson - same as 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHF</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASHD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hour</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9-19</b> , 19 <b>86</b> , to <b>9-25</b> , 19 <b>86</b> , that (I) (we) last saw the deceased alive on <b>9-24</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <b>William Kent Faust MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-25-86</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM FAUST</b>				22e. ADDRESS <b>11701 LININGSTON RD. FT WASHINGTON MD. 20744</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-27-86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cheltenham Method. Cheltenham Pr. Geo. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>HUNTT FUNERAL HOME</b>				P. O. Box 156 ADDRESS <b>Waldorf, Md. 20601</b>		25a. DATE REC'D BY REGISTRAR <b>SEP 29 1986</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. Rodriguez

BP

W.D. KAY

BOX 11011-10318

00-19704

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 8 4 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Jessie Elziabeth Wilson						September 25, 1986				2:35P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		caucasian		MONTH DAY YEAR 2 23 1903		83 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Prince George's MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel		Greater Laurel Beltsville Hospital						Housewife		Home	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Md.			Howard		Highland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7521 Brown Bridge Rd. 20777		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
Howard Thompson			Mary Sullivan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS			
no			216-40-8525		Edward D. Wilson			3919 Bonnybridge Rd. Ellicott City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Anterior Myocardial Infarction</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Colicomy for diverticular bleeding</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
9/18/86		bleeding diverticulosis				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>86</u> , to <u>9/25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Richard M. Chasen</u>				M.D.				9/26/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Richard M. Chasen M.D.				7100 Center Road Laurel, Maryland 20707							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		9/29/86		Union Cemetery		Burtonsville		MONT.		MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
FLECK Funeral Home, Inc. Laurel, MD				7601 Sandy Spring Rd. ADDRESS				OCT 02 1986			

MEDICAL CERTIFICATION

BP



00-19628

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 6 2 6 8 4 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BARBARA J WISE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 20 86</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 19 1934</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>52</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Pr Geo</b>		13c. CITY OR TOWN <b>Dist Hts</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>unobtainable</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unobtainable</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-54-8664</b>		17. INFORMANT ADDRESS <b>Nellie Weston Same as #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>BRONCHOPNEUMONIA, Hypertensive arteriosclerosis, Heart disease, Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1</b> , 19 <b>86</b> , to <b>Sept 20</b> , 19 <b>86</b> , that (I) (we) lost saw the deceased alive on <b>Sept 20</b> , 19 <b>86</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Helen Capone</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Sept 21-86</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Helen CAPONE MD</b>		22e. ADDRESS <b>7501 SURRATTS Rd # 105 Clinton MD 20735</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>25 Sept 1986</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>	
24. FUNERAL HOME NAME <b>Robert E Wilhlem Funeral Home</b>				25. DATE REC'D. BY REGISTRAR <b>SEP 29 1986</b>			
25b. REGISTRAR'S SIGNATURE <b>Julia Tidwell-Randall</b>							

BP

C. J. CHAPMAN

00-19541

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 4 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Raper Wise			2a. DATE OF DEATH MONTH DAY YEAR September 26, 1986			2b. HOUR 8:05A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 16, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.			
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7734 Washington Blvd. #117 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Darius D. Raper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Spence					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 261-41-8742		17. INFORMANT ADDRESS Mrs. Gwendolyn Fisher, Same as Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC LUNG DISEASE</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONGESTIVE HEART FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <u>9/27</u> 19 <u>85</u> to <u>9/26</u> 19 <u>85</u> that (b) (we) last saw the deceased (live on above) <u>9/25</u> 19 <u>85</u> and that (c) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>G. A. Conaton</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9-26-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. A. CONATON MD				22e. ADDRESS 4201 LAUREL PARK DR #221 20707 LAUREL MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-30-86		23c. NAME OF CEMETERY OR CREMATORY Old Hollywood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pasquotakt Co.			
24. FUNERAL RECORD NAME ADDRESS FRANCIS CASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 29 1986		25b. REGISTRAR'S SIGNATURE <u>John H. Hurd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if the death was due to a traumatic event, the medical examiner must be notified at once.

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00-19829

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 4 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
JOHN B. WOOD				SEPT 25 86		1205 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Caucasian		April 9, 1911		75	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Ridge, Maryland		U.S.A.				PRINCE GEORGES CO MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CLINTON		So. MARYLAND Hosp.		Warehouse Worker		Safeway Food	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		P. G.		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		13f. STREET ADDRESS	
John		Anna		8310 Mimosa Avenue		20735	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17b. ADDRESS	
No		N/A		James R. Wood		7102 Loena St. Forestville Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18b. SOCIAL SECURITY NO.		17. INFORMANT		17b. ADDRESS	
PART I. DEATH WAS CAUSED BY:		578-01-4904A		James R. Wood		7102 Loena St. Forestville Md	
IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
RESPIRATORY FAILURE						10 min	
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) CEREBROVASCULAR ACCIDENT						2 mo	
DUE TO, OR AS A CONSEQUENCE OF							
(c) Diabetic arteriosclerotic Cordi						15 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RECORDED TO THE PERMANENT RECORD							
SEPSIS - E. COLI and STAPH. EPIDERMIDIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED			
SEP 24 1986		Arthur Shaver, M.D.		9/25/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE	
ARTHUR SHAVER MD		9131 PISCATAWAY RD CLINTON MD 20735		OCT 01 1986			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		09.29/86		Resurrection Cemetery		Clinton Prince George's Md	
24. FUNERAL DIRECTOR		24b. NAME		24c. ADDRESS		24d. DATE REC'D. BY REGISTRAR	
Lee Funeral Home, Inc.							
6633 Old Alexander Ferry Rd Clinton, Md 20735							

BP



00-18732

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
255A
 BP  
DHMH - 17  
(VR A15 ME (5))

 FOR  
1- STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Pearl Mae Woodruff</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>9-13 1986</b>		2b. HOUR MIN <b>230 A</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 14 1912 74 YRS.</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>74 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. CITY OR TOWN OF DEATH <b>Capitol Hts</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS <b>4105 Southern Avenue #1B</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dietician retired</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		12c. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr George</b>		13c. CITY OR TOWN <b>Capitol Hts</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Luther C Hicks</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>George W Woodruff Jr</b>		16. SOCIAL SECURITY NO. <b>227-12-6770</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>227-12-6770</b>		17. INFORMANT ADDRESS <b>386 Crabapple</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>atherosclerosis</b>					
19a. DATE OF OPERATION <b>Sept 13 1986</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Myocardial infarction</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Myocardial infarction</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 P.M. 1986</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Myocardial infarction</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5009 Rayburn Ct, Temple Hills, MD</b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>9-13-86</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>		ADDRESS <b>5009 Rayburn Ct, Temple Hills, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>18 Sept 86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>		23e. DATE REC'D. BY REGISTRAR <b>SEP 22 1986</b>		23f. REGISTRAR'S SIGNATURE <b>Robert E Wilhelm</b>	
24. FUNERAL HOME NAME ADDRESS <b>Funeral Home Suitland, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>SEP 22 1986</b>			

19-12-82  
9-13-82

Pauline Woodroff

Franklin



My dear Mr. Woodroff,

My dear

Chapman

9-13-82

00-18897

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST DAVID	MIDDLE C	LAST WOODS	2a. DATE OF DEATH		MONTH 9	DAY 13	YEAR 86	2b. HOUR 3:40pm	M M
3. SEX Male		4. RACE Black		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY		MD.			
10. CITY OR TOWN OF DEATH CLINTON MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN BALTIMORE CITY, MARYLAND HOSPITAL)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland				13b. COUNTY P.G.		13c. CITY OR TOWN Temple Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3400 27th Ave, 20748	
14. FATHER'S NAME FIRST UNKNOWN				MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST Willie				MIDDLE C. LAST Woods	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-66-2086		17. INFORMANT ADDRESS Willie C Stephens Swint 3400 27th Ave.					
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prothrogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with recurrent disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) 1							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on <u>9/13/86</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9.14.86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Laxima Berwa, MD				22e. ADDRESS 7503 Serratts Rd, Clinton, Md 20735							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-19-86		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery		23d. LOCATION CITY OR TOWN Sutland		COUNTY PG		STATE Maryland	
24. FUNERAL DIRECTOR NAME Robert G. Mason				ADDRESS 1661 Good Hope Rd, SE				75a. RECEIVED BY REGISTRAR (DATE) SEP 23 1986			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be filled in by the funeral director. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



0-17358

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by Dr. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6

2 6 8 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DANIEL J. WOTRING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-4-86</b>			2b. HOUR <b>12:45 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 23, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>So. Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maj. USAF</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11905 Piscataway Rd. 20735</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel J. Wotring</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Madge Mundell</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		17. INFORMANT ADDRESS <b>Eveline Wotring Same as 13 A-E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uncontrollable Variceal Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF - (b) <b>Cirrhosis &amp; Portal Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alcoholic Cirrhosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Coagulopathy consumptive</b>									
19a. DATE OF OPERATION <b>9/4</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Massive Bleeding</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> , 19 <b>86</b> , to <b>9/4</b> , 19 <b>86</b> , that (I) (we) last saw the deceased <b>over on</b> <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE <b>[Signature]</b>			DEGREE			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Colover</b>			22e. ADDRESS <b>7501. SURREATTS RD 20735 CLINTON MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>09/05/86</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clinton Prince George's Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home, Inc.</b>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>SEP 8 1986 John Davidson-Randall</b>			

DHMH - 16 60M 7/84

(VRA 15, 4)

6613 Old Alexander Ferry Rd. Clinton, Md 20735



James T. McGowan

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James T. McGowan



00-19234

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 6 8 5 0

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
*Phillip H. Wrightson Sr.*

2a. DATE KNOWN OF DEATH  
ESTIMATED ☒ MONTH DAY YEAR  
9-24-86

2b. HOUR

3. SEX

*Male*

4. RACE

*White*

5. DATE OF BIRTH  
MONTH DAY YEAR

*4-22-32*

6. AGE (IN YEARS)  
LAST BIRTHDAY

*54* YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

*9-24-86*

2d. HOUR

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
*South Carolina*

7b. CITIZEN OF WHAT COUNTRY?  
*U.S.A.*

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH  
*Prince Georges Co.* MD.

10. CITY OR TOWN OF DEATH  
*Lanham*

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
*Doctors Hospital of P.H. Co.*

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
*Plumber*

12b. KIND OF BUSINESS OR INDUSTRY  
*Self-Emp.*

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
*Md.*

13b. COUNTY  
*Pr. Geo's.*

13c. CITY OR TOWN  
*Lanham*

13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS  
*9600 Franklin Ave.*

14. FATHER'S NAME  
FIRST MIDDLE LAST

*Samuel*

*Wrightson*

15. MOTHER'S MAIDEN NAME  
FIRST MIDDLE LAST

*Louise*

*Hawkins*

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.  
*1950-1952*

17. INFORMANT  
ADDRESS  
*9783 Goodluck Rd.*

*Yes*

*1950-1952*

*251-44-0005*

*Philip G. Wrightson, Jr. Seabrook, Md.*

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Arteriosclerotic cardiovascular disease*

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?  
YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
*P.M. 19*

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Augusto P. Rodriguez* TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) *Augusto P. Rodriguez, M.D.* ADDRESS *5009 Rayburn Ct., Temple Hills, MD*

DATE SIGNED *9-24-86*

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial*

23b. DATE *9/27/86*

23c. NAME OF CEMETERY OR CREMATORY *Cedar Hill Cem.*

23d. LOCATION CITY OR TOWN COUNTY STATE *Suitland P.G. Md.*

24. FUNERAL DIRECTOR NAME *London/Hale Lanham Funeral Home*

25a. DATE REC'D. BY REGISTRAR *SEP 29 1986*

25b. REGISTRAR'S SIGNATURE *John Davidson*

25c. REGISTRAR'S NAME *John Davidson*

25d. REGISTRAR'S ADDRESS *9013 Annapolis Rd. Lanham, Md. 20706*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))

ONE  
WRA  
2000



1/2

00-20092

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 6 2 6 8 5 1

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	M
Jennie				Yambor	9-30-86				2AM	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	7a UNDER 1 YEAR		7b UNDER 24 HRS		
Female	Caucasian	November 5, 1925			60	YRS.		MONTHS	DAYS	HOURS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia	USA				Prince Georges MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Greenbelt	24 R Ridge Road			Housewife			Housewife			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS					
Maryland		Pr. Geo.	Greenbelt	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	24 R Ridge Road		20770			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME								
Louie		Daraban		Mary Slovic						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS						
No		216-80-0902		Daughter 1229 Spencerville Rd. Pamela Yambor Spencerville, Md. 20868						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, LIVER</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
		8-30-86 9-30-86	
22a I certify that (I) (this hospital) attended the deceased from <u>8-30-86</u> , 19 <u>86</u> , to <u>9-30-86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>9-20-86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.			
22b SIGNATURE <u>Bruce W. Gattis</u>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 9-30-86	
22d MEDICAL JAR 5 NAME (Not on front) Bruce W. Gattis, M.D.	22e ADDRESS 14333 Laurel-Bowie Rd. 20708 Laurel, Md.		

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Cremation	Sep. 30, 1986	Metropolitan Crematory	Alexandria Virginia
24 FUNERAL DIRECTOR NAME	25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Francis J. Collins, Jr.	OCT 06 1986		<u>[Signature]</u>
500 University Blvd., W. Silver Spring, Md.			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

